AN EXAMINATION OF BUREAUCRATIC BARRIERS TO CARE FOR VETERANS

HEARING

BEFORE THE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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AN EXAMINATION OF BUREAUCRATIC BARRIERS TO CARE FOR VETERANS

Thursday, June 12, 2014

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C.

The committee met, pursuant to notice, at 9:15 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

Present: Representatives Miller, Bilirakis, Roe, Flores, Runyan, Benishek, Huelskamp, Coffman, Wenstrup, Cook, Walorski, Jolly, Michaud, Brown, Takano, Brownley, Titus, Kirkpatrick, Ruiz, McLeod, Kuster, O'Rourke, and Walz.

Also Present: Representative McNerney.

The *Chairman.* The committee will come to order.

Thank you, everybody, for coming to this hearing this morning. We have numerous Members that are on their way, but we want to respect the time of our witnesses, and we appreciate them being with us today.

But before I begin, I want to ask unanimous consent to allow our colleague and former committee member, Congressman McNerney of California, to sit at the dais and participate in today's hearing. Without objection, so ordered.

So welcome to today's full committee hearing on Examination of Bureaucratic Barriers to Care for our Veterans.

As we all know very well now, during a committee oversight hearing in early April, we came forward with the results of a committee investigation that had uncovered evidence suggesting that dozens of veterans died while waiting for care at the Phoenix Department of Veterans' healthcare system.

Just over two months later, we know now that in addition to 23 veteran deaths at the department linked to delays in care earlier this spring, at least 35 more veterans died while awaiting care in the Phoenix area alone.

What is more, a VA audit released earlier this week found that over 57,000 veterans have been waiting 90 days or more for their first VA medical appointment and 64,000 veterans who have enrolled in the healthcare system over the last decade never received the appointment that they requested.

That is 121,000 veterans who have been waiting for care to be provided that they earned. That number exceeds the population of

several mid-size U.S. cities like Athens, Georgia, Abilene, Texas, or Santa Clara, Texas, or even Evansville, Indiana, and I fear there is more yet to come.

Yesterday I spoke to a group of VA providers from across the country at an event for the National Association of VA Physicians and Dentists speaking about the current crisis engulfing the department. They have said that VA's procedures and processes are inconsistent, inconsistently applied, and often prevent efficient use of personnel.

The statement echos the serious calls for alarm that we have heard from others over recent weeks.

During a recent committee hearing, Dr. Daigh, VA's assistant inspector general for VA's Healthcare Inspection, testified that VA suffers from, and I quote, "a lack of focus on healthcare delivery as priority one," unquote.

As a result, quote, "several organizational issues that impede the efficient and effective operation of the VA healthcare system and place patients at risk of unexpected outcomes," end quote.

In an article published last week in the New England Journal of Medicine, a former VA under secretary for Health, Dr. Ken Kaiser, and a current staff physician at a major VA medical center wrote that the systemic data manipulation and lack of integrity VA is experiencing are but, quote, "symptoms of a deeper pathology because simply VA has lost sight of its primary mission of providing timely access to consistent high-quality care," end quote.

All of these remarks go to prove what we have already known. The VA healthcare system and the bureaucratic behemoth that accompanies it is complex and its problems are even more complex.

I believe that the majority of VA's workforce, in particular the doctors and nurses who provide our veterans with the care they need, do, in fact, endeavor to provide high-quality healthcare.

Unfortunately, VA leadership has failed those employees almost as much as it has failed our veterans and correcting those failures is going to take a lot more than the band-aid fixes the department has proposed thus far.

It is going to take wholesale systematic reform of the entire department starting with holding senior staff accountable.

VA hasn't gotten where it is today due to just bloated and ineffective middle management or lack of training and professional development for administrative staff or inefficient or nonexistent productivity and staffing standards or cumbersome and outdated IT infrastructure.

The department got where it is today due to a perfect storm of settling for the status quo. VA cannot continue business as usual. It is very clear the status quo is not acceptable and it is time for real change, again, beginning with accountability up to the highest levels of VA bureaucracy.

And I hear repeatedly from the VA about its delivery of high-quality, patient-centered care, but this committee, republicans and democrats alike will not rest until we hear that same assessment from every single veteran seeking care. It is time for VA to tell us the bad news, not just the good news.

STATEMENT OF THE HONORABLE JEFF MILLER, Chairman

Welcome to today's Full Committee oversight hearing, "An Examination of Bureaucratic Barriers to Care for Veterans."

As we all well know, during a Committee oversight hearing in early April, we came forward with the results of a Committee investigation that had uncovered evidence suggesting that dozens of veterans died while waiting for care at the Phoenix Department of Veterans Affairs (VA) health care system. Just over two months later, we know now that in addition to twenty-three veteran deaths that the Department linked to delays in care earlier this spring, at least thirty-five more veterans died while awaiting VA care in the Phoenix, Arizona, area.

What's more, a VA audit released earlier this week found that over fifty-seven thousand veterans have been waiting ninety days or more for their first VA medical appointment and sixty-four thousand veterans who have enrolled in the VA healthcare system over the last decade never received the appointment they requested. That is one-hundred and twenty-one thousand veterans who have not been provided the care they have earned.

That number exceeds the population of several mid-sized U.S. cities like Athens, Georgia, or Abilene, Texas, or Santa Clara, Texas, or Evansville, Indiana. And, I fear that there is more yet to come.

Yesterday I spoke to a group of VA providers from across the country at an event for the National Association of VA Physicians and Dentists (NAVAPD). Speaking about the current crisis engulfing the Department, NAVAPD has stated that VA's, "procedures and processes are inconsistent, inconsistently applied, and often prevent efficient use of personnel..." This statement echoes the serious calls for alarm we have heard from many others in recent weeks.

During a recent Committee hearing, Dr. Daigh [DAY], VA's Assistant Inspector General for Healthcare Inspections, testified that VA suffers from, " . . . a lack of focus on health care delivery as priority one," as a result of, " . . . several organizational issues that impede the efficient and effective operation of [the VA health care system] and place patients at risk of unexpected outcomes."

In an article published last week in the New England Journal of Medicine, a former VA Under Secretary for Health – Dr. Kenneth Kizer - and a current staff physician at a major VA medical center wrote that the systemic data manipulation and lack of integrity VA is experiencing are but, " . . . symptoms of a deeper pathology," because, "[q]uite simply, VA has lost sight of its primary mission of providing timely access to consistently high-quality care."All of these remarks go to prove what we already know. The VA health care system and the bureaucratic behemoth that accompanies is complex and its problems are even more complex.

I believe that the majority of VA's workforce – in particular, the doctors and nurses who provide our veterans with the care they need – endeavor to provide high-quality health care. Unfortunately, VA leadership has failed those employees almost as much as it has failed our veterans and correcting those failures is going to take a lot more than the band-aid fixes the Department has proposed thus

far – it is going to take wholesale systematic reform of the entire Department, starting with holding senior staff accountable.

VA hasn't gotten where it is today due to just bloated and ineffective middle management; or lack of training and professional development for administrative staff; or inefficient or nonexistent productivity and staffing standards; or cumbersome and outdated IT infrastructures. The Department got where it is today due to a perfect storm of settling for the status quo. VA cannot continue business as usual. The status quo is unacceptable. It is time for real change – again, beginning with accountability up to the highest levels of VA bureaucracy. I hear repeatedly from the VA about its delivery of high-quality, patient- centered care . . . but this Committee will not rest until we hear that same assessment from every veteran seeking care. It is time for VA to tell us the bad news, not just the good.

With that, I yield to our ranking member, Mr. Michaud, for any opening statement he might have.

OPENING STATEMENT OF THE HON. MIKE MICHAUD, Ranking Minority Member

Mr. MICHAUD. Thank you very much, Mr. Chair, for having this very important hearing, Examining the Barriers to Care for our Veterans.

This is a unique time in the history of the Department of Veterans Affairs. We as a committee have been responsible for bringing to light systematic problems, many dating back over a decade.

But as we are shining the light on these problems, we must also begin to take steps to address them. I am proud that this committee has addressed these problems in a bipartisan fashion and I am hopeful that the spirit continues as we roll up our sleeves and begin the hard work of finding solutions.

The VHA is a sprawling organization with over six million unique patients, facilities spread all over the country, and nearly 275,000 employees and a $56 billion budget. To put VA, the largest integrated healthcare system in the country, in perspective, VHA is roughly the equivalent of five Mayo Clinics combined.

Recent admissions of wrongdoing are shameful and the practice will not be tolerated. The systematic lapse of integrity confirmed by the internal VHA access audit and the VA OIG reports points to a bureaucratic bureaucracy that has seemed to have lost its way and its focus.

I think these problems, the time is right to begin discussing how best to address these challenges and the time might be now to effect big changes that will put the focus back on the veteran and away from the culture of complacency.

In our discussion of reform, I want to make sure that we are not just rearranging the desk chairs. All the reorganization in the world will be futile without a strong base of values.

I do not doubt the commitment of the vast majority of VA employees. However, sometimes we all know that we need to be reminded of who we are here to work for. We are here to work for the veteran, brave men and women who have sacrificed so much for our freedom, men and women who right now deserve better.

I strongly suggest that VHA develop a code of conduct or a caregiver culture that will become ingrained throughout the organization regardless of whether there is one VISN or 50. Working in the VA requires the utmost integrity.

As Dr. Roe pointed out the other night, all a VA employee needs to do without a doubt is they have to be reminded that they are working for the veteran, not a bureaucracy.

As with most things, there are tradeoffs. We are looking at structural reform, centralization versus decentralization, standardization versus innovation. These discussions have been ongoing for years, if not decades.

I would like to think VHA is an adaptable, learning organization that can make needed transformation, but let me be clear. The only way we are going to truly address the litany of problems is to look at the fundamental change within the department.

And rightfully we are all looking at ways to address the problems as we see today, but I am also hopeful that our ambitious schedule of hearings in the weeks ahead will think anew about how best to provide the quality, comprehensive care to our veterans in a timely fashion.

And I hope that they challenge us to think anew about how to refashion systems and infrastructure, management and personnel policy and procedures to address the access issues head on and to help the VA live up to its ideal.

I believe it is essential that we look at structural and cultural root causes that got us in this position in the first place.

We have heard that the leadership of the medical centers feels disenfranchised. We have real concerns over the effective level of accountability. We need to shorten the feedback loop from the front-line provider to VHA leadership.

One of the discussions we must have is over the right administrative structure of the VHA, how to ensure that policies and procedures are followed nationally while making sure that the VA is not a one-size-fit-all system.

We have heard many times about the excessive, intrusive administrative burden our providers experience which takes time away from caring for our veterans. We need to do what we can to eliminate this administrative work.

Many are pointing to the IT infrastructure. There is no doubt that an outdated scheduling system contributes to the current problems and needs emergency upgrade. At the same time, we need more detail on what is happening to the millions of dollars Congress has appropriated for IT.

Before we can look at investing even more money here, I want to know why the VA did not do a better job in planning strategically, anticipating the needs of a facility system population, and putting in place actions including things like IT upgrades to address these anticipated needs.

The time is right to leverage outside expertise. There is no monopoly on good ideas. I look forward to hearing from the panels today and hope to continue this excellent discussion throughout the coming weeks.

PREPARED STATEMENT OF THE HON. MICHAEL MICHAUD

* Thank you Mr. Chairman.

* This is a unique time in the history of the VA. We. As a Committee, have been responsible for bringing to light systemic problems, many dating back for over a decade. But as we are shining light on these problems, we must also begin to take steps to address them. I am proud that this Committee has addressed these problems in a bipartisan fashion, and I am hopeful that this spirit continues as we roll up our sleeves and begin the hard work of finding solutions.

* The Veterans Health Administration is a sprawling organization, with over 6 million unique patients, facilities spread out all over the country, and nearly 275,000 employees and a $56 billion budget.

* To put VA, the largest integrated health care system in the country in perspective, VHA is roughly the equivalent of five Mayo Clinics combined.

* Recent admissions of wrongdoing are shameful and the practices will not be tolerated. The systemic lapses of integrity confirmed by the internal VHA access audit and VA Office of Inspector General reports point to a bureaucracy that has seemed to lose its way, and its focus.

* I think with these problems, the time is right to begin discussing how best to address these challenges, and that the time might be now to effect big changes that will put the focus back on the veteran, and away from a culture of complacency.

* In our discussions of reform, I want to make sure we are not just rearranging the deck chairs. All the reorganization in the world will be futile without a strong base of values.

* I do not doubt the commitment of the vast majority of the VA employees. However, sometimes we all need a reminder of who we work for.

* And we work for veterans – brave men and women who have sacrificed so much for our freedom. Men and women who, right now, deserve better.

* I strongly suggest that VHA develop a code of conduct or a caregiver culture that will become engrained throughout the organization regardless of whether there is one VISN or fifty.

* Working in the VA is a particularly special government service and requires the utmost integrity. As Dr. Roe pointed out the other night, all VA employees need to know without a doubt they are working for our veterans.

* As with most things, there are tradeoffs when looking at structural reforms. Centralization versus decentralization, standardization versus innovation, these discussions have been ongoing for years if not decades.

* I would like to think the VHA is an adaptable learning organization that can make needed transformations.

* But let me be clear – the only way we are going to truly address the litany of problems is to look at fundamental change.

* Rightfully, we are all looking at ways to address the problems we see today. But I am hopeful that our ambitious schedule of hearings in the weeks ahead challenge us to think anew about how

best to provide quality comprehensive health care to our veterans, in a timely fashion. I hope that they challenge us to think anew about how to refashion systems and infrastructure, management and personnel, policy and procedures to address the access issue square-on, and to help the VA live up to its ideal.

* I believe it is essential that we look at structural and cultural root causes that got us into this position.

* We have heard that the leadership of the medical centers feels disenfranchised. We have real concerns over the effective level of accountability. We need to shorten the feedback loop from frontline providers to the VHA leadership.

* One of the discussions we must have is over the right administrative structure of the VHA – how to ensure that policies and procedures are followed nationally, while making sure that VA is not a "one-size-fits-all" system.

* We have heard many times about the excessive and intrusive administrative burden our providers experience, which takes away time from caring for veterans. We need to do what we can to eliminate this administrative work.

* Many are pointing to the IT infrastructure. There is no doubt the outdated scheduling system contributed to the current problems and needs emergency upgrades. At the same time, we need more details on what happened to the millions of dollars Congress has appropriated for IT. Before we look at investing even more money here, I want to know why the VA did not do a better job at planning strategically – anticipating the needs of facility-specific populations, and putting in places actions – including things like IT upgrades – to address those anticipated needs.

* The time is ripe to leverage outside expertise. There is no monopoly on good ideas. I look forward to hearing from our experts today and hope to continue an excellent discussion through the coming weeks.

* Thank you Mr. Chairman, I yield back.

Joining us today, we actually have two panels. On our first panel already seated at the table is the Honorable Tim McClain, president of Humana Government Business; Mr. Dan Collard, chief operating officer for The Studer Group; and Dr. Betsy McCaughey, chairman for the Committee to Reduce Infection Deaths.

We do appreciate all of you being here with us today. And with that, Mr. McClain, you are recognized for five minutes.

STATEMENT OF TIM S. MCCLAIN

Mr. MCCLAIN. Thank you, Mr. Chairman.

And, Mr. Chairman, Ranking Member Michaud, and Members of the committee, thank you for holding today's hearing to Examine Bureaucratic Barriers to Healthcare for Veterans.

I will focus my remarks on the very complex subject of organizational impediments in the Veterans Health Administration that are not conducive to the delivery of good healthcare to veterans.

In my written statement, which I ask be made a part of the record——

The *Chairman.* Without objection, all of your statements will be entered into the record.

Mr. MCCLAIN. —I make four specific recommendations to improve organizational alignment in VHA. But in this oral statement, I want to address just one, and it is probably the one that is most disturbing to veterans and Congress, and that is a failure of ethics.

There is a pervasive VA culture that puts personal gain and the system over the needs of the veterans and this is wrong. And I want to make two points to the committee. Let's not have Congress and VA just put band-aids on the current crisis without resolving the systemic causes and, two, I believe any long-term solution must include a culture and organizational assessment by a nationally recognized company.

The current crisis differs from previous VA crises by the fact that it reflects a serious cultural deficit throughout VA at certain levels of management. This is to the culture of what should be at VA.

Now, I want to emphasize and make it clear that from my experience at VA, I found the vast majority of VA employees to be competent, professional, and dedicated to the primary mission of serving veterans, but the culture at certain management levels reflects an attitude of personal gain over service to veterans.

Some major changes are required. But before making any major changes, I proposed in my written statement that VA be directed to contract with a nationally recognized company to conduct a top to bottom assessment of the current culture. A gap analysis can then be performed to determine the current state and then what is needed to move the VA system to a veteran-centric 21st century system.

The experience will be influenced by what I will call the voice of the veteran which essentially is direct veteran input into what this culture should look like going forward. If Congress or VA fails to seize the once-in-a-generation opportunity to deliver a modern VA healthcare and benefit system, we will all be back in this hearing room in the future lamenting the then current crisis.

Mr. Chairman, this concludes my oral statement. I would be glad to answer any questions. Thank you.

PREPARED STATEMENT OF THE HON. TIM S. MCCLAIN

Thank you for holding today's hearing to examine bureaucratic barriers to healthcare for Veterans. I will focus my remarks on the very complex subject of organizational impediments in the Veterans Health Administration (VHA) that are not conducive to the delivery of effective and efficient healthcare to our nation's most deserving citizens.

The following recommendations are submitted for the Committee's consideration to drive VHA organizational alignment for improving healthcare delivery to Veterans:

I. A cultural assessment is recommended and should be completed before any major organizational changes are implemented

II. Develop and implement a national Integrated Care Delivery (ICD) Model pilot program in several Community Based Outpatient Clinics (CBOCs) with a focus on health outcomes, cost of care, and Veteran satisfaction

III. Utilize existing commercially available technology, such as health IT and scheduling/ consult tracking tools, to improve care

coordination for Veterans who utilize VHA's "in-network" and "out-of-network" providers

IV. For national or congressionally-directed programs, the program offices in VHA central office should be empowered to enforce policies and directives by providing organizational authority, centralized budgetary control, and meaningful outcomes-oriented performance metrics

I. A cultural assessment is recommended and should be completed before any major organizational changes are implemented

Recent articles have opined that many of the current problems in the Veterans Health Administration are the result of an organizational culture that does not put the Veteran at the center of care and looks inward rather than outward for ideas and innovation. The alleged actions of certain VA employees in Phoenix and other VA facilities support those assertions. I believe the vast majority of VA employees are professional and dedicated to their primary mission of serving Veterans. However, there is a pervasive attitude among some levels of management that preservation of the "system" takes precedence over all other considerations,

including Veteran-centric healthcare. The result is an overall attitude that fears outside influence over VA healthcare. The paramount objective is to treat all Veterans within the walls of VHA, even if that means the patients must wait for care and even when some Veterans prefer to get care in the community. Sending a Veteran into the community for primary care is viewed as a potential weakness which might be exploited by those that want to provide Veterans an alternative to care closer to home. In many locations, VHA considers care delivered by a contracted community provider to be inferior to VHA care.

In a recent article in the New England Journal of Medicine, Dr. Kenneth Kizer described VHA's current attitude as "insular."

This attitude is in direct contrast to how contracted care is viewed by a system such as Kaiser Permanente. Patients in the Kaiser system refer to the "Kaiser Experience", where care delivered anywhere within the Kaiser network, in a Kaiser hospital or a contract community provider, is considered Kaiser healthcare and part of the Kaiser Experience.

VHA should embrace this concept and move toward a "VA Experience" which incorporates all available quality healthcare and services in a community, including a modern Integrated Healthcare Delivery Model.

The cultural issues identified are most likely not restricted to VHA, but may be present throughout VA.

Recommendations:

1. After addressing the most immediate access problems, Congress should direct VA to contract with a national company or organization experienced in conducting cultural and organizational assessments of large, complex healthcare and/or service organizations.

2. VA should allow the voice of the Veterans to define the ideal "VA Experience". Then, VA should conduct a gap analysis and compare the results of the current cultural and organizational assessment to the desired Integrated Care Delivery Model of a 2020 and beyond world-class healthcare and services organization of choice.

3. VA should review all Personnel evaluation metrics and ensure that all VHA employees – from clerks, to clinicians, to senior managers – are evaluated based on outcomes for Veterans who are seeking and receive care from VHA – within its walls or in the community.

4. With the assistance of national experts, VA should develop and implement a plan to move from its current organizational culture to the desired 2020 and beyond world-class organizational structure and culture.

II. Develop and implement a national Integrated Care Delivery (ICD) Model pilot program in several Community Based Outpatient Clinics (CBOCs) with a focus on health outcomes, cost of care, and Veteran satisfaction

The transformation of VHA in the 1990s from a hospital-centric to a clinic-based system occurred, in part, as a reaction to a desire to provide accessible care to Veterans in the face of limited and dwindling budgetary resources. VISNs were established, there was a shift away from hospital-based inpatient care to outpatient care, and VHA became the decentralized system it is today. Over the past decade, VHA's budget has increased significantly and today budgetary restrictions are much less of a driving force. However, along with the growth of the budget came the growth of middle management positions at VA. The number of VA employees ballooned from 230,000 to over 320,000 in just five years. It appears that the vast majority of the additional employees are not engaged in direct healthcare. The bureaucracy is bloated. Also, Congress in appropriating the huge increases to the VA budget failed to require accountability for health and benefits outcomes for the taxpayers' dollars.

Over the next ten years VHA must continue its focus on addressing the signature injuries of the wars in Iraq and Afghanistan. In addition, there must be an equal focus on wellness and prevention to drive improved population health outcomes. As VA's budget stays flat or diminishes, as it surely will as the wars wind down, focusing on Integrated Care and population health are two proven ways to control rising healthcare expenditures by keeping the Veteran population in good health as the Vietnam era Veterans age.

There is abundant research that links wellness and preventive services to improved health outcomes. However, the way that VHA is currently organized does not integrate wellness and prevention into patient care plans and Veterans do not receive a consistent set of wellness services from one VAMC to the next. A pivot to Wellness is needed in VA.

Recommendations:

5. To drive positive health outcomes, realize cost savings and improve Veteran satisfaction, VHA needs to focus on further developing a Veteran-centric, care coordinated delivery system that strongly promotes wellness and prevention. This requires policies and attitudes on these issues that are implemented consistently across the continuum of care as Veterans seek care within and outside of VHA. This will also assist VHA in making the VHA system the portal of choice for Veterans' healthcare.

6. Congress can work with VHA to design a standardized, Veteran-centric healthcare delivery system, which is based on Integrated Care Delivery, care coordination and wellness.

a. VHA budget allocations should be dependent on VHA incorporating the policies, procedures, and programs designed so that VHA is the healthcare system of choice for Veterans.

b. Congress should direct VHA to establish a pilot program in several CBOCs, including contracted CBOCs, to determine the effectiveness of an Integrated Care Delivery model on health outcomes and cost of care.

i. Today, both VA and contractor-run CBOCs provide much of the primary care to eligible Veterans. The CBOCs serve as a natural home for extending wellness services as a test bed for the proposed coordinated and Integrated Care Delivery Model.

ii. To fully understand the impact of integrating wellness offerings through the CBOCs, VHA should implement a pilot program in select VISNs that captures metrics and outcomes in both VHA and contractor-operated CBOCs that are representative of the variety of CBOCs that VHA operates. The pilot program must include provisions that allow CBOCs to experiment with various health and wellness approaches to determine the most effective and efficient model.

iii. To ensure VHA and Congress are provided actionable information on these pilots, there must be a rigorous, independent evaluation component to the pilot program that focuses on care quality, cost, and Veteran satisfaction.

III. Utilize existing commercially available technology, such as health IT and scheduling/ consult tracking tools, to improve care coordination for Veterans who utilize VHA's "in-network" and "out-of-network" providers

The Electronic Health Record (EHR) is a critical component for robust care coordination. It is especially important for Veterans with co-morbid mental and physical health conditions that see multiple providers, both "in-network" providers within VHA and "out-of-network" providers outside of VHA.

VHA does not maintain a complete Veterans Health Record because it fails to capture, aggregate, and evaluate a Veteran's care from all sources, both inside and outside VHA. A significant portion of VA patients do not receive their entire healthcare from VHA. Some only come to VA for the prescription drug benefit. Therefore, VA does not have a complete picture of a Veteran's overall healthcare needs and treatment. VistA is an effective EHR tool to be used within each VHA facility; however, it is not ideal for an Integrated Care Delivery Model because it fails to aggregate charts, labs, consults and reports from all sources of a Veteran's healthcare. The technology exists today in the Health IT space to accomplish this important aspect of total healthcare.

Currently when a Veteran receives an authorization for care through the Purchased Care Program, VHA essentially loses track of that Veteran's healthcare because there is no tool to track the healthcare delivered by providers in the community. This may be one reason why care provided in the community is suspect to many in VHA. An EHR that presents the total healthcare picture of a Veteran could help to alleviate that attitude.

Recommendations:

7. Complete clinical information exchange is a key element of care coordination. VHA should be directed to:

a. Utilize off-the-shelf solutions that exist today in the commercial market that will provide immediate connectively between VistA and EHRs that are used in systems outside of VHA. VistA evolution plans should ensure VHA IT can easily be linked with other existing IT tools and products that will enhance health care delivery for Veterans.

b. Leverage existing Health IT capabilities in the commercial sector to aggregate and evaluate health data from all healthcare delivery sources. This includes the power of big data and data analytics to study and positively impact population health outcomes.

8. Implement a national, centralized appointment scheduling system in VHA with a centralized budget and location(s).

a. A national scheduling system will provide the opportunity for any Veteran to be scheduled for any appointment in or out of Network anywhere Veterans are eligible to receive care. There are numerous commercially robust scheduling systems in use today that VHA could adopt.

b. Project HERO (Healthcare Effectiveness through Resource Optimization), a care coordination pilot program, utilized a contractor-provided scheduling and consults tracking system, which allowed VHA to track a Veteran's total healthcare experience when referred to a community provider. Such a system could be used to schedule and monitor the appointments for all purchased care. This centralized appointment system for contract care would be a tool for VHA in managing the delivery of timely access to care for Veterans.

c. VHA still lacks a nationwide state-of-the-art claims processing system. Each facility still has unique capabilities and approaches to paying for out of Network (Purchased Care/Fee) claims. In addition, VHA still lacks an automated system for collecting first and third party payments, which should be an integral part of an in-Network and out-of-Network claims payment system.

IV. For national or Congressionally-directed programs, the program offices in VHA Central Office should be empowered to enforce policies and directives by providing organizational authority, centralized budgetary control, and meaningful outcomes-oriented performance metrics

Properly managed, the decentralized model of VHA implemented in the mid-1990s has been a very effective model. However, some programs have required a national implementation approach, as directed by Congress. For those programs, offices in VHA Central Office establish national policies and issue guidance, but they lack direct line and centralized budget authority for ensuring that the policies are implemented and guidance is followed consistently in the field.

As mentioned above, Project HERO was a care coordination pilot program that yielded savings of $16 million according to VA's calculations, even with a very limited use of the pilot program in the field. VHA missed a major opportunity to realize savings. Significant additional savings could have been realized if the Project HERO program office had centralized authority to implement a standardized authorization and referral process, and the authority

to require a facility's use of the contracted network of outside providers in the pilot program.

Many existing VHA performance metrics are focused on process rather than outcomes, which hinders the ability to hold staff accountable to program success and improved Veterans' health outcomes.

Recommendations:

9. VHA should establish clear performance metrics that focus on clinical results, quality, access, timeliness, and Veteran satisfaction. These metrics would guide the work of VHA's administrative and clinical staff in central office and in the field. In addition, it would be an effective lever to drive desired behavior if these metrics are used to inform the staff's annual performance reviews and decisions about bonus awards and promotions.

10. The field staff – administrative and clinical - needs to have a clear reporting chain to eliminate the current confusion about the chain of command, authority and responsibilities. For example, there are VISN BIMs (Business Implementation Managers) with different organizational structures across the country. Some VISN BIMs have direct line authority over the Fee clerks at VAMCs and can direct their behavior, while other VISN BIMs lack that authority.

Mr. Chairman, thank you once again for the opportunity to address these extremely important issues. Humana Government Business stands ready to assist VHA in finding solutions to the current issues so that Veterans can receive the timely care they deserve.

Honorable Tim S. McClain

Tim S. McClain was appointed President, Humana Government Business in February 2012 and has responsibility for business and administrative contracts with the federal government. Previously, Tim was President and CEO of Humana Veterans Healthcare Services. He is a recognized expert in Veterans health care law and policy.

Mr. McClain has over thirty- five years of experience in executive leadership and management positions. He served as General Counsel for the U.S. Department of Veterans Affairs (VA) from 2001–2006, a Senate-confirmed Presidential appointment position, serving two Cabinet secretaries and managing an office comprised of nearly 400 attorneys.

In 2005, Mr. McClain served concurrently as General Counsel and as Chief Management Officer for VA, with overall responsibility for the Cabinet department's budget formulation and execution, procurement policy, acquisitions management, and business process oversight.

Tim is a graduate of the U.S. Naval Academy, Annapolis, Maryland, and California Western School of Law, San Diego, California. He is a retired Naval officer, having served as a Surface Warfare Officer and in the Navy's Judge Advocate General's (JAG) Corps.

Statement:

Humana Government Business currently provides administrative services to VHA under the Project ARCH (Access Received Closer to Home) contract, and also operates thirty-four Community Based Outpatient Clinics (CBOC) through contracts with VHA. Humana

Government Business previously provided services under the Project HERO contract.

The *Chairman.* Thank you very much, sir. We appreciate your comments.

Mr. Collard, you are recognized for five minutes.

STATEMENT OF DAN COLLARD

Mr. COLLARD. Chairman Miller, Ranking Member Michaud, and committee Members, thank you for this hearing as well. Thank you for the opportunity to address the committee on the issues of veterans' health and the underlying elements of culture and leadership.

I listened with interest Monday night when I heard Mr. Griffin from the Inspector General's Office talk about the fact that if you have seen one VISN, you have seen one VISN. And it seems that both the testimony of your witnesses and your questions centered around evidence and variance.

In Studer Group's work with over 900 healthcare organizations across our country, it is clear that those that implement standardized approaches to care produce the very best outcomes. These organizations build culture of accountability, alignment, consistency, and sustainability.

We also find that their evidence-based approaches extend beyond evidence-based care to a framework of evidence-based leadership. This approach ensures that leaders are not only held accountable for the right goals, but these leaders are given the skills and the tools and the knowledge to achieve those goals. These leaders ensure consistency in the workplace for their employees. They also ensure consistency in the care environment for their physician colleagues.

And as the public has watched the VHA issues unfold over the past 60 days, it is clear that the tolerance for variance is chief among its ailments. The amount of variance and the lack of willingness to standardize leadership has created an unfortunately predictable outcome. As we would say, what you permit, you promote.

The data that demonstrates these connections of evidence-based care, quality outcomes, patience experience, and lower cost just continue to mount. When one reviews the publicly reported data, it is clear that better healthcare is less costly healthcare. Data also suggests a strong correlation between patients' perception of care and the actual clinical outcomes.

Further, there is data that correlates the specific questions like preparation for at-home care with the likelihood of a readmission.

A review of the VHA facilities that report show that only a handful appear in the top core tile, a few just above the national mean, and unfortunately way too many in the lower ranks of healthcare.

You connect this proof with the fact of employee engagement and one begins to see definite trends. A study published recently by the University of Alabama at Birmingham showed clearly the correlation between the level of employee engagement and the likelihood of the creation of work-arounds which equals impact on safety.

I was reminded of that as I read the various reports of what we now know from the whistle blowers about the veterans' wait lists and the related mortalities.

Largest healthcare systems in the United States have driven improvements by harvesting and implementing best practices across their systems. When organizations like Community Health Systems identify a best practice, they move quickly to put the practice in place across all 205 facilities. This includes patient safety protocols, caregiver-to-patient interactions about medications, and a leader accountability platform.

I was concerned when I heard the witnesses on Monday reference the amount of time they thought it would take to make change. As Harvard business professor John Kotter would have us remember that the biggest obstacle to achieving high performance is not achieving the needed urgency.

And, Mr. Walz, I think this was actually part of the answer to your question about the big idea on Monday. No matter what is decided, the VA must embark upon change with a never-before-seen sense of urgency with a proven outcomes-based solution.

We observe at Studer Group that it can be as straightforward as transferring the rigor and discipline of where an organization already excels into an area where they are sub-par.

For instance, imagine if the VHA electronic medical record, which is hailed as cutting edge, could be the impetus for creating the scheduling software, which is today archaic at best.

Imagine if the high-performing facilities referenced in Monday's testimony that stand out as models could be those models and indeed replicated with what Mr. Matkovsky referred to as exceptional leadership and culture. We wouldn't have tolerated the operation of 21 different navies or armies, air forces, marines, or coast guards when these veterans were on active duty. Why do we tolerate 21 versions of veterans' health today in our VISNs?

Our Armed Forces also ensure readiness by putting in place systems of verification and validation of skills for both front-line sailors and soldiers as well as those leaders. We find safe, effective, timely healthcare to be no different.

And, finally, we have to make sure that the Veterans Health Administration doesn't continue to fall victim to this disease process known as terminal uniqueness. Many healthcare organizations work with an organized labor environment. Many have large geographic footprints with a corporate office thousands of miles from where the care is being delivered. Many organizations serve a large indigent or disadvantaged patient population and, yet, these organized organizations find a way to not only survive but thrive.

I ask that this committee would compel the secretary and his leadership team to move forward with urgency, implement standardized evidence-based approaches across the enterprise, ensure methods of validation and verification, and make sure that this all supports outcomes, focus, leadership development to ensure the consistency.

I ask this today not only as a healthcare professional but as the son of a deceased marine corps veteran whom I saw all too often let down by the VA. Thank you.

PREPARED STATEMENT OF DAN COLLARD

Mr. Chairman, Ranking Member Michaud and Committee Members:

My name is Dan Collard. I am a former hospital operator and a senior leader at Studer Group, a healthcare consulting firm.

Thank you for the opportunity to address this committee on the issue of Veterans' Health and the underlying elements of culture and leadership.

I listened with interest Monday night, when I heard Mr. Griffin from the Inspector General's office make the statement, "If you've seen one VISN, you've seen one VISN. It seems both the testimony of the witnesses and your questions centered on evidence and variance.

In Studer Group's work with over 900 healthcare organizations, it is clear that those that implement standardized approaches to care, produce the best outcomes. These organizations build cultures of accountability, alignment, consistency and sustainability. We also find that their evidence-based approaches extend beyond evidence-based care, to a framework of "evidenced-based leadership". This approach ensures that leaders are not only held accountable for the right goals, but have the skills, tools and knowledge to achieve those goals. These leaders ensure consistency in the workplace for their employees and consistency of the care environment for their physician colleagues. As the public has watched the VHA issues unfold in the past sixty days, it is clear that the tolerance for variance is chief among its ailments. As referenced repeatedly, the amount of variance and the lack of willingness to standardize leadership has created an unfortunately predictable outcome. As we would say, "What you permit, you promote."

Evidence: The data that demonstrates the correlation between evidence-based care, quality outcomes, patient experience and lower costs continues to mount. When one reviews the publicly reported data, it is clear that better healthcare is less costly healthcare. Data also suggests a strong correlation between a patient's perception of care and actual clinical outcomes. Further, there is data that correlates specific questions like preparation for at-home care and the likelihood of readmission. A review of VHA facilities within publicly reportable readmission databases indicates only a handful that appear in the top quartile, a few more above the national mean, and unfortunately too many in the lower ranks of American healthcare.

Connect this proof with employee engagement and one begins to see definite trends. A study published by the University Alabama at Birmingham shows the correlation between employee engagement and the likelihood of the creation of workarounds which increases safety issues. I was reminded of this study as I read the various reports of what we now know from whistleblowers about the veterans' wait lists and the related mortalities.

On standardization: The largest healthcare systems in the United States have driven improvements by harvesting and implementing best practices across their systems. When organizations like Community Health Systems identify a best practice, they move with urgency to put the practice into place across their 205 facili-

ties. This includes patient safety protocols, caregiver to patient interactions around medication instructions and a leader accountability platform. I was concerned when I heard the witnesses reference the amount of time they thought it would take to make changes. As John Kotter reminds us, the biggest obstacle to achieving high performance is not achieving the needed urgency for change. Mr. Walz, I think this is part of the answer to your question about the Big Idea. No matter what is decided, the VA must embark upon change with a never-before-seen sense of urgency and with a proven, outcome based solution.

Studer Group observes that it can be as straightforward as transferring the rigor and discipline from areas in which an organization excels to areas that are sub-par. Imagine if the VHA electronic health record or benefits management systems that have been hailed as cutting edge could be the impetus to create scheduling software whose current version is archaic at best. Imagine if the high-performing facilities referenced in earlier testimony could be held out as models and indeed replicated with what Mr. Matkovsky refers to as "exceptional leadership and culture." We wouldn't have tolerated the operation of 21 different navies or armies, air forces, marines or coast guards when these veterans were on active duty. Why would we tolerate 21 versions of Veteran's Health? Our armed forces ensure readiness, by putting in place systems of verification and validation of skills . . . of both front line soldiers and sailors as well as their leaders. We find safe, effective, timely healthcare to be no different.

Finally, we must insist that the Veterans Health Administration does not continue to fall victim to the disease process known as "terminal uniqueness". Many health systems work with an organized labor environment. Many have a large geographic footprint with a corporate office thousands of miles from where care is being delivered. Many organizations serve a large indigent and disadvantaged patient population. And yet these organizations find a way to not only survive, but thrive.

I ask that this Committee compel the secretary and his leadership team to move forward with urgency, standardize evidence-based approaches across the entire enterprise, ensure methods of validation and verification are put into place and support outcomes-focused leadership development to ensure consistency across what should be the greatest health system in the country. I ask this today, not only as a healthcare professional, but as the son of a deceased Marine Corp veteran, whom I saw all too often let down by the VA. Thank you.

The *Chairman.* Thank you, Mr. Collard.

Dr. McCaughey.

STATEMENT OF BETSY MCCAUGHEY

Ms. MCCAUGHEY. Thank you.

I am Betsy McCaughey, former lieutenant governor of New York State——

The *Chairman.* If you could check your——

Ms. MCCAUGHEY. —a huge advocate and chairman of the Committee to Reduce Infection Deaths.

I have spent a good deal of my career in infection prevention in hospitals and I admire many of the achievements of the VA in that area. But I am here today to express my concern that this bill passed in the Senate yesterday, the McCain-Sanders bill, will not save the lives of vets stuck on the wait list.

This bill as currently written is designed to protect union jobs, not ailing vets. In fact, the VA is run largely by unions and for unions. And one of the culprits is this 316 page union contract full of mind-numbing rules that prevent assigning an employee to a new task, a new work shift, a new building, or reprimanding someone on the staff for misdeeds or just poor performance.

Nine months ago, the VA rolled out a $9.3 billion initiative to allow vets who were stuck on wait lists to access civilian care, but the unions fought it as hard as they could. The American Federation of Government Employees labeled it in their newsletter, The Worker, an attempt to dismantle the VA brick by brick. That is not true, but they vilified it that way.

And this current bill sabotages the ability of vets to access civilian care in three ways. First of all, it requires, and I am referring to Section 301 starting on page 21 since I am sure you will be reading the bill, it requires that any vet wanting to access civilian care get a letter from the secretary of the VA confirming that the vet has waited an unacceptable amount of time for treatment or lives more than 40 miles from a VA medical center.

Good luck getting that letter. I talk to vets all the time who have contacted the VA, called them, emailed them every day for six months and couldn't get a reply.

Secondly, if the VA does manage to get the letter and get the choice card and get to a civilian doctor, then he has to hand the card to the doctor who is instructed to call the VA and get prior approval before treatment.

Good luck getting somebody to answer that phone call.

And, thirdly, most preposterously, this bill states that this choice program will end in two years. In other words, a few hours after the VA manages to finally get the hotline up and get the cards distributed to vets, it will be over.

So there is a way to solve this problem and put the vets in the driver's seat. And I am going to credit the Rand researchers with this idea because the fact is that almost half of vets stuck in these waiting lists are seniors. They are 65 or older and they are virtually all on Medicare.

If they were encouraged to seek non-combat-related care, age-related care as such bypass surgery, angioplasty at civilian hospitals, particularly teaching hospitals, it would reduce the backlog by as much as half, solving this national crisis.

And in many cases, vets would get better care because the mortality rates at the teaching hospitals associated with many of these

VA medical centers are much lower. They are high-volume hospitals and they do these age-related procedures all the time. What is holding the seniors back is lack of knowledge about that resource.

And, secondly, the co-payments, the out-of-pocket expenses, we could give those vets who are already on Medicare a special VA Medigap card. It is budget neutral. You are already paying for the care and, yet, it would allow them to access better care. It would reduce the wait list and it would allow vets who have fought for our freedom, it would allow them the freedom to get the care they need.

Thank you for this opportunity.

PREPARED STATEMENT OF BETSY MCCAUGHEY

Chairman of the Committee to Reduce Infection Deaths

Before the House Committee on Veterans' Affairs

On "An Examination of Bureaucratic Barriers to Care for Veterans"

June 12, 2014

PUBLIC EMPLOYEE UNIONS WILL SABOTAGE VETS SEEKING CIVILIAN CARE

Chairman Miller, Ranking Member Michaud, and members of the Committee, thank you for inviting me to testify before you today. My name is Betsy McCaughey, Ph.D. I am a former Lt. Governor of New York State, a patient advocate, and Chairman of the Committee to Reduce Infection Deaths.

I have concerns that even the recently passed legislation will not save the lives of vets currently stuck on wait lists for care.

The unions that dominate the VA run it as a jobs program for the benefit of their own members, not vets. The union contracts are filled with mind-numbing rules that prevent workers from being given a new task, moved to a new shift, or disciplined for shoddy work or dishonesty. The VA is run for workers, not patients.

The biggest culprit is the American Federation of Government Employees, or AFGE. The union wants more patients, bigger VA budgets, and more staff, never mind what ailing vets need.

Nine months ago, the VA rolled out a $9.3 billion program to refer vets needing specialists to civilian medical centers, if the wait at their local VA facility is too long or they live too far away. That is exactly the same thing the Sanders/McCain bill purports to do. AFGE fought the program from day 1, even accusing VA executives of deliberately causing the backlog. "Create a Crisis and then outsource the work," the union's newsletter, The Worker, states.

Vets have been discouraged from accessing civilian care even when they've desperately needed it and have insurance to pay for it. Here's the reason: The VA's healthcare budget is based on how many vets enroll and how much care they use. For unions, the bigger the budget the better. Even if it means letting vets with Medicare who could get timely civilian treatment for their cancer or heart disease die in a VA wait line instead.

AFGE President J. David Cox insists the only remedy for the VA's wait lists is more VA staff. "Chronic understaffing" is the problem, he says. How can he know? VA hospitals have no clue

how many staff they have or need. A 2012 audit by the VA Inspector General found that the agency's hospitals lacked any method for calculating staffing needs, in part because of resistance to measuring worker productivity.

Shockingly, one million vets who seek care at the VA are covered by Medicare Advantage, the private plans the federal government purchases for seniors. Astoundingly, the VA spends 10 percent of its medical care budget treating seniors who have Medicare Advantage. Yet the federal government also pays over $3 billion a year to Medicare Advantage insurers to cover the same people. Paying for the same care twice. What a waste. But as long as the unions dominate the VA, these inefficiencies and corruption will not be fixed.

Even with legislatively directed non-VA care, mischief will continue. They are discouraging vets from actually accessing care outside of the VA system. And here are the roadblocks sabotaging vets getting outside care:

The veteran needing care must receive a letter from the Secretary confirming that an appointment at the VA is not available. Good luck getting that letter. We know about Vets who have called and emailed their VA hospital daily for six months without getting any response at all.

The civilian doctor must telephone a VA hotline to get prior permission before providing care. Good luck to the Doctor trying to get the VA on the line in a timely manner.

Should the Sanders/McCain "Choice Card" come to fruition, after setting up all these new procedures, the choice card program will expire in two years—probably only a few hours after the VA finally gets the hotline set up and issues the cards.

And the House version, H.R. 4810, passed unanimously Tuesday, still relies on the VA to spell out what Veterans really need. The bill stipulates that veterans will be covered for outside care "including all specialty and ancillary services deemed necessary as part of the treatment recommended . . . " Necessary according to whom? Recommended by whom?

In short, VA staff cannot be trusted to deal honestly with vets needing care. The VA's own internal investigation revealed on Monday that 76% of VA facilities doctored appointments or kept dummy books.

Remedies:

There is a better way to solve this problem. Let's put the Vets themselves in the driver's seat. There are two age groups of veterans we're concerned about: seniors and those under 65.

Almost half of Vets (45%) enrolled in the VA health care system are 65 or older. Virtually all of them are on Medicare, according to RAND researchers. Encouraging vets on Medicare to use civilian care instead of the VA could cut the VA's patient backlog by as much as half, solving a national crisis.

Most VA hospitals have links to nearby teaching hospitals where older vets can get cardiovascular and cancer surgery with better survival rates than at most VA hospitals. These civilian hospitals, which perform higher volumes of these age-related procedures, have better outcomes. Sadly, the VA fails to tell seniors that.

And the long waits in the VA system increase the risk of needless death. Boston VA researchers found patients aged 70 to 74 who wait more than 31 days for treatment face a 9 percent increased risk of stroke.

Low-income senior veterans are most likely to stick with the VA. One reason is that out-of-pocket costs are lower there than with Medicare. But that can be rectified easily, as RAND researchers recommend.

Vets could be issued a special Medicare card that eliminates the Part B premium and reduces Part B copays and deductibles to the small fees the VA charges ($15 for a primary care visit, $9 for 30 days of medications, $50 for specialist visits.) This would be budget-neutral because either way federal tax dollars are picking up the excess cost.

Thank you again for your time and the opportunity to appear before the Committee today, and I will be glad to answer any questions you may have.

Betsy McCaughey, Ph.D.

Betsy McCaughey is a patient advocate and former Lt. Governor of New York State. In 2004, she founded and is now Chairman of the Committee to Reduce Infection Deaths (also known as RID), a nationwide educational campaign to stop hospital-acquired infections. In five years, RID has made hospital infections a major public issue. It has provided compelling evidence that preventing infection improves hospital profitability as well as saving lives, and RID has won legislation in over 25 states for public reporting of infection rates. RID has become synonymous with patient safety and clean hospital care.

Betsy McCaughey's research on how to prevent infection deaths has been featured by the Wall Street Journal, Good Morning America, the CBS Morning Show, ABC's 20/20, and many other national media outlets.

Betsy McCaughey is the author of over three hundred scholarly and popular articles on health policy, infection, medical innovation, the economics of aging, and Medicare. Her writings have appeared in The New York Times, The Wall Street Journal, New Republic, Policy Review, Forbes Magazine, New York Law Journal, Los Angeles Times, U.S. News & World Report, and many other national publications. Her 1994 analysis of the dangers of the Clinton health plan in The New Republic won a National Magazine Award for the best article in the nation on public policy. She has been profiled in The New Yorker, The New York Times Magazine, New York Magazine, The Washington Post, and other publications. She writes a weekly column for Investors Business Daily and Creators Syndicate.

Prior to entering the health policy field, Betsy McCaughey earned a Ph.D. in constitutional history from Columbia University. She is the author of two books on that subject. She has taught at Vassar College and Columbia University, and she produced prize-winning studies while at two think tanks, the Manhattan Institute and later the Hudson Institute.

From 1995 to 1998, she served as Lt. Governor of New York State. She focused on health issues, and her bills became models for legislation in many states and in Congress.

The *Chairman.* Thank you, Dr. McCaughey.

Mr. Collard, I will start with you, but anybody that wants to answer this question, feel free. Each Member will have five minutes. And we also have a round of votes. That is why evening hearings on return nights are so good. We don't get interrupted with votes.

But my staff recently obtained an email in the supervisory chain, how many levels there are between the scheduler and the secretary, and, of course, the scheduling clerk is called medical support assistant, shows 12 layers of bureaucrats and middle managers between those two people.

Is that surprising?

Mr. COLLARD. It is not surprising, but it is clearly an indicator of the issue. On the private sector, you wouldn't think about care could be rendered in a safe, timely fashion with 12 layers of leadership between someone in the trenches and someone making the decision.

It also creates the greater opportunity for the variance in communication, the variance in setting expectations. The layers just create the permutations for communication within the VA.

The *Chairman.* Anybody else want to comment?

Ms. MCCAUGHEY. And how about the time it takes, all that communication? This is time. And, you know, one of the studies that just recently came out showed that when an older vet is forced to wait 90 days or more for treatment, it increases the risk of stroke by nine percent. That is a study right out of the Boston VA Medical Center. So this time is critical to saving the lives of these vets. That is why they are dying in these wait lines.

The *Chairman.* Tell me, if you would, how does this structure compare to your experience in observing other medical centers or systems, Mr. McClain?

Mr. MCCLAIN. I do not have a lot of experience in observing other medical centers. Humana for the most part is a health and wellness and Medicare Advantage company. We do a lot of business with VA and we have seen the difficulty that we have as a contractor in also getting certain answers and certain things changed or done for the betterment of the veteran.

The *Chairman.* Mr. Collard.

Mr. COLLARD. We would find traditionally no more than three or four layers. I was with an organization yesterday and it was the traditional structure of a senior leadership team, directors, managers, and right to the front line.

The *Chairman.* And I think, Mr. Collard, you may have, but others of you may have also alluded to this as well. The number of healthcare networks that exist across this country,

. You have a large system.

How many networks should there be? I mean, surely it should be broken up somehow, but 21?

Mr. COLLARD. Even if the number stayed 21, the ability to standardize across the 21 is really the key. You know, healthcare is always local no matter whether it is private sector or government. Healthcare is always local because we are serving local veterans.

But the ability to say whether it needs to be 21 or six, really the underpinnings of that, when you lift up the hood on that is the

ability to standardize across no matter how many regions or VISNs or divisions that you have.

The *Chairman.* Dr. McCaughey.

Ms. MCCAUGHEY. Yes. One of the problems is really quite simple and it has been pointed out in many of the reports that have been submitted to Congress over the last decade including the one that was presented on Monday and the one that was presented by the General Accountability Office in March of 2013.

And that is that vets are assigned an appointment and then months go by and nobody calls them to remind them a day or two before the appointment that they are supposed to come. That is a practice that is always done in private sector medicine. Every doctor's office, every clinic, every hospital calls patients and reminds them to show up for their appointment.

The result of this failure is that in some departments like ophthalmology, according to the GAO report submitted to you last March, the no-show rate is 45 percent. So when you say you don't have enough appointments and enough doctors, almost half of them are going to waste and, yet, why every year does another report have to remind the VA to call the patients and nothing is done about it.

The *Chairman.* My time is about to expire, but if you could, as succinctly as possible, what is the greatest single barrier that exists out there today within the VA to providing timely healthcare?

Mr. MCCLAIN. And I am going to go off from what Mr. Collard said is standardization. You have all heard it. If you have seen one VA, you have seen one VA. And there is too much, I guess, flexibility or variability in how services are delivered and how veterans can access services at each of the VA facilities.

Mr. COLLARD. When you standardize your practice, you create greater predictability and outcomes. Whether it is an attorney, a finance expert, a healthcare expert, they would all agree that when you standardize your mode of practice, you create greater predictability and outcomes. And it is the outcomes that I think ultimately this panel has to be able to address and not just the process of care measures that we are talking about.

The *Chairman.* Thank you.

Dr. McCaughey.

Ms. MCCAUGHEY. Yes. I would like you to focus on the failings of this bill because pretty soon, you are going to be voting on it or compromising with the vote you took in the House to create a final bill. And that final bill that you create has to remove these impractical impediments.

Otherwise, you are not passing a bill to give vets access to civilian care. It will be a charade if they have to get a letter from the secretary and if there has to be a call made to get prior approval for the treatment. Just remember that, please, as you compromise with the Senate.

Thank you.

The *Chairman.* Thank you.

Mr. Michaud, you are recognized.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Mr. McClain, one of your recommendations is to review all personnel evaluation metrics and ensure that all VHA employees from

clerk to clinician to senior managers are evaluated based on outcomes for veterans who are seeking and receiving care from VHA.

Mr. Collard, you also urge the VA to support outcomes and focus on leadership.

My question to you two is the over-reliance on metrics has been mentioned as one of the factors leading to the current wait time problems.

How do you distinguish between metrics and outcomes, Mr. McClain?

Mr. MCCLAIN. Thank you, Mr. Michaud.

My short answer to that would be that most of the metrics that are reported today in VHA, and there are hundreds of them, are process oriented and simply checking a box or doing something versus actually measuring what that accomplishes or the outcome.

And so my point in making that was that we should be rewarding and measuring outcomes for veterans, good health outcomes rather than simply checking the box and doing a process.

Mr. COLLARD. I would add that it is just the sheer size of the numbers of metrics. I went the HR route and pulled a middle manager's evaluation within the VA today, you would see metrics scored by the dozens. And if you think about that many metrics, how can a leader give any proper attention and proper priority.

When you have a weighted evaluation around those that are outcomes versus process, you have the ability to create focus and priority, and that is what I would say it is not just the metrics, but the sheer number of metrics that we are looking at.

Mr. MICHAUD. Thank you.

Is it valid to have a strategic metric, Mr. McClain?

Mr. MCCLAIN. I think that it is valid to have a strategic goal as to what the outcomes might be and be measured against that goal. I think that is valid.

Mr. MICHAUD. Mr. Collard.

Mr. COLLARD. Look over on the——

Ms. MCCAUGHEY. I wanted to point out——

Mr. MICHAUD. Mr. Collard, would you answer?

Mr. COLLARD. Go to the CMS Web site and you will see one of the metrics. What the private sector is really paying a lot of attention to right now is readmissions. We know the fact that a tactic like a post hospitalization phone call has the ability to reduce readmissions and, yet, what we don't do is we don't measure hospital operators on the number of post visit phone calls that they make because in the publicly reportable Web sites that you would find, you would find the actual readmission rates for folks within certain disease categories.

Mr. MICHAUD. Okay. Thank you.

Some within the VA has raised concern that there are inadequate numbers of extenders and this causes physicians to spend undue time with paperwork and routine clinical work.

Mr. McClain, what does the private sector use as a benchmark for the physicians to physician extender ratio?

Mr. MCCLAIN. Well, it varies depending on what type of clinic. Our involvement are with the community-based outpatient clinics. We operate 34 of those under a contract with the VA. And so we utilize VA's for the most part panel size of 1,200 per physician and

then the support, the medical and also administrative support for a single doctor would be somewhere four or five support personnel for that doctor.

Mr. MICHAUD. Mr. Collard.

Mr. COLLARD. I would defer to Mr. McClain.

Mr. MICHAUD. Okay. Thank you.

Doctor, my question for you would be, I am interested in your comments on the VA paying for care for patients already covered by Medicare Advantage and the potential for the government paying for care twice.

What policy changes could remedy this situation?

Ms. MCCAUGHEY. Well, it is very interesting that such a large percentage of vets actually have insurance. Only about ten percent of vets being treated at the VA are, quote, uninsured. And it is probably tragic that they weren't included in the Affordable Care Act.

But nevertheless, many of these vets who are insured either with employer-based insurance or Medicare Advantage or regular Medicare or Medicaid resist going outside of the VA system because of the out-of-pocket expenses.

And as I explained before, if we gave them the Medigap card for the seniors particularly, a Medigap card, a special VA Medigap card that absorbed those out-of-pocket expenses, they could seek a lot of care in civilian hospitals, particularly teaching hospitals that are high volume for angioplasty, bypass surgery, hips and knees, some of the things that seniors frequently need. So they would be getting in many cases better outcomes, not always better, but often better, and it is budget neutral for us. As a Nation, it is budget neutral.

Mr. MICHAUD. Thank you.

And, incidentally, under the Affordable Care Act, 3,000 Mainers were denied access because our government refused to extend Medicaid to the 70,000 Mainers of which 3,000 were veterans. So thank you.

Thank you, Mr. Chairman.

The *Chairman.* Thank you.

Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it.

I thank the panel.

My first question is for the entire panel. Many have mentioned and stated the VA has lost its focus of their primary responsibility of caring for our veterans.

Do you agree? Maybe let's start with Mr. McClain, please.

Mr. MCCLAIN. Yes, Mr. Bilirakis, I do agree.

Mr. BILIRAKIS. And also Mr. Collard.

Mr. COLLARD. Yes.

Mr. BILIRAKIS. Yes. Doctor.

Ms. MCCAUGHEY. Yes.

Mr. BILIRAKIS. All right. Now, tell me where you think their focus has been. We can start with Mr. McClain.

Mr. MCCLAIN. The current focus, I think, has gone off the veteran and has gone on to preserving the current system. I think that there is a lot of if it is not invented here, we don't want to hear about it.

So there is not a lot of invitation for innovation to come in and partner with VA in order to move it into a more modern healthcare system. So where I see it is it is, as Dr. Kaiser stated, a more insular system right now.

Mr. BILIRAKIS. Mr. Collard.

Mr. COLLARD. Two answers really. I spent time with a VA leadership group in one of the western regions last year and I heard for probably two hours more reasons about why we couldn't do something versus why we could do something.

I also think that sometimes we feel that standardization stifles innovation and I don't think it could be any further from the truth. When you have a standardized platform in any industry, you actually have pretty fertile ground for innovation because once an innovation takes hold, you now have a platform by which you can harvest, distill, and disseminate those best practices through innovation across an enterprise.

But I think what happens, as I would associate with Mr. McClain's comment, the ability to attach to the way we have always done things is really probably that barrier of focusing on veteran-centered care.

Mr. BILIRAKIS. Doctor.

Ms. MCCAUGHEY. Yes. I would like to point out two things. One is that, as I mentioned in my opening statement, in the 1990s, the VA really took an admiral lead in patient safety and particularly in prevention of nosocomial or hospital acquired infections.

Lately we have seen less and less of this. Dr. Jane who has now taken a bigger job at the VA has done some wonderful work in the prevention of methicillin-resistant staphylococcus aureus.

But in general, that pioneering effort to protect patient safety that I saw in the 1990s has disappeared somewhat from the culture. That, and as I pointed to that before, how can you have a focus on the patient when you have 316 pages of rules about what employees can and cannot do just from one union, just from one.

This contract governs the work rules for 200,000 people who work at the VA and it is preventing a focus on the patient.

Mr. BILIRAKIS. Thank you.

Next question, do you believe the VA's shortcomings and failed benchmarks was the result of inadequate funding or management of resources, Mr. McClain?

Mr. MCCLAIN. I personally don't think it was the result of inadequate funding. The VA budget has really increased significantly in the past five or six years. But I think pretty obviously it is a mis-allocation of those resources.

Mr. BILIRAKIS. Mr. Collard.

Mr. COLLARD. Not only a mis-allocation, but perhaps just looking the other way when you have the resources. I think I heard on Monday night the fact, Chairman Miller, that you raised, a specific financial number that has been invested or been provided for IT and IT-related services and the question was raised, where is the money.

And so whether it is a mis-allocation or just perhaps an ignoring of those funds available perhaps leads to the current state.

Mr. BILIRAKIS. Dr. McCaughey.

Ms. MCCAUGHEY. Yes. The VA budget has increased 173 percent from the year 2000 through 2012. That in inflation adjusted terms is 72 percent. The increase in total VA patients was 69 percent. So the funding increased at a faster pace than the number of patients who had to be treated. And the number of acute care patients who need costly care increased only 49 percent. So the VA funding should have been adequate to meet the increased demands on the system.

Mr. BILIRAKIS. Okay. Last question, a very important question, how would you rate VA's urgency to change its culture and become more patient centered for the veteran? And we will start with Mr. McClain again.

Mr. MCCLAIN. I don't see any urgency.

Mr. BILIRAKIS. Mr. Collard.

Mr. COLLARD. Could I have you restate the question again?

Mr. BILIRAKIS. Okay. How would you rate VA's urgency to change its culture and become more patient centered for the veteran?

Mr. COLLARD. On a numeric scale, very low if we are rating it in current state.

Mr. BILIRAKIS. Dr. McCaughey.

Ms. MCCAUGHEY. I agree with that.

Mr. BILIRAKIS. Thank you very much. I yield back, Mr. Chairman.

The *Chairman.* Thank you.

Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. McClain, your testimony encourages the VHA to adopt a more inclusive approach to contract of the care along the lines of the Kaiser Permanente model and the, quote, "Kaiser experience."

How do you respond to VHA concerns with the continuity of care and record transfers?

Mr. MCCLAIN. Well, I respond to it, and we have some direct experience in this having done Project HERO and currently doing Project ARCH, is that VA doesn't favor outside care for the most part. In other words, they favor the biases to treat everything within the walls.

The success of the Kaiser experience is that they view all care that is delivered in one of their networks as part of Kaiser care and that is part of the Kaiser experience. In other words, the people who are going outside into a community provider feel that that is just part of the Kaiser system.

Part of the issue is that currently VA, although the VistA system is a terrific system for electronic health records, it does not have the ability to collect those consults and primary care charts that are on the outside. And that is one of the things in my written testimony that I proposed is there is IT currently available that will consolidate and aggregate all of the care of a veteran whether it is delivered inside of a VA medical center or outside so that the provider in the VAMC has a complete picture of the veteran's health.

Mr. TAKANO. Could you comment on the capacity of the private sector care providers, what percentage of them are ramped up to be able to utilize the software?

I have heard that, you know, a relatively small percentage of providers have the capacity or have updated to electronic records.

Mr. MCCLAIN. I don't have that number in front of me. I couldn't testify to that, sir.

Mr. TAKANO. Well, thank you.

Mr. Collard, Mr. McClain, regarding cost management, would you find that the veterans, the VHA, and the way they deal with prescription drugs and pharmaceutical costs is a good thing?

I have heard that they actually use their size to leverage down those costs.

Mr. MCCLAIN. The answer is, yes, I think they do a pretty good job. By statute, VA actually purchases drugs in bulk for DoD and VA and the Indian Health and coast guard. And so by statute, the manufacturer is required to give them a discount off of commercial rates. And so actually VA does a very good job in purchasing drugs.

Mr. TAKANO. Mr. Collard.

Mr. COLLARD. I would concur.

Mr. TAKANO. So does that same sort of approach exist with Medicare?

Mr. MCCLAIN. Not to my knowledge.

Mr. TAKANO. And would that contribute to out-of-pocket costs for senior citizens generally, do you think?

Mr. MCCLAIN. You know, sir, I haven't looked at that. I don't have an opinion on that.

Mr. TAKANO. Well, thank you.

You know, Mr. Walz, I could yield my time to you if you have any questions. I am kind of done.

Mr. WALZ. I thank you all and come back to it.

Mr. McClain, you are right and I really appreciate some of the ideas that are coming out of this. And this idea that is being brought up of how do we get the big idea, how do we get to the big idea.

I guess one of my concerns is, and I would ask on a comparison, this is to you, Dr. McCaughey, you carried around this, I would just—this is the collective bargaining agreement between St. Mary's Hospital, the Mayo Clinic, and their healthcare provider. It doesn't make as good a theater as a big one, but it is still there.

I would make the argument that the Mayo Clinic delivers good, quality healthcare. Your assertion is is it is totally based on the collective bargaining of the people there I don't believe in any way moves this argument forward.

So my question to you is, when was the last time you personally were in a VA hospital and tell me about your experience there as you talked to the providers and talked to those nurses at the nursing station?

Ms. MCCAUGHEY. Well, I actually just talked to some of the people at the VA hospital here in D.C. a few minutes ago. And let me explain that they are——

Mr. WALZ. Have you been out there?

Ms. MCCAUGHEY. Right. I haven't been to their hospital yet, but I have talked to them. And let me explain that they are also concerned about the mismanagement or mis-allocation of staff resources.

It is so bad, for example, that at some of the VAs, and I know you will probably confirm this, the physician has to spend a lot of time going out to the waiting room, getting the patient, explaining how to disrobe, doing a lot of things that in another hospital or clinic would be done by ancillary staff so that doctors can see not two patients an hour or three but maybe six.

Some of this is a problem with union rules. And to say that it isn't is just preposterous.

Mr. WALZ. So it is happening at Mayo?

Ms. MCCAUGHEY. I haven't read their agreement. But to say that unions are not part of this problem is just—read the American Federation of Government—just let me finish. You asked me to come here.

Mr. WALZ. Didn't you answer?

Ms. MCCAUGHEY. That is not true. In a democracy, we both get to talk.

Mr. WALZ. Mr. Chairman, I will yield back my time.

The *Chairman.* Time is expired.

Ms. MCCAUGHEY. Thank you.

I would like to explain, sir——

The *Chairman.* Dr. Roe.

I apologize. We are very short on time.

So, Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

Mr. McClain, I think you are 100 percent correct. The VA needs to go through a top-down look from an outside agency. It doesn't need to be evaluated within anymore. It needs to have an outside look.

And what Mr. Michaud said is absolutely correct. The VA could do one thing today. I said this Monday night at the hearing. The years I spent in clinical practice in medicine, I knew who I worked for and that was the patient. That was the center of why I was there. If I didn't have patients to see, I had no reason to be in an office.

And if you ask anybody on a VA campus who they work for, they will say the VA. The answer should be we work for veterans. That should be the answer and that is a simple change in philosophy to change. I don't have any reason to be at this VA if there are not veterans there for me to care for.

So I think you could do that one thing and I think the top-down approach, I think you are spot on. And I think several things were brought up.

Just interestingly, Mr. McClain, you mentioned that a CBOC that you ran, that the VA had four to five personnel to help, ancillary people to help. In our office, and I practiced for 31 years, it is about three people.

And you can even get more efficient the bigger you get. You don't need another scheduler if you add another doctor. You need another medical assistant. You may need another lab person, whatever, but you get much more efficient. Typically it is three to one and sometimes even less if you are very good at it. And we were very good at it and very efficient.

The incentives that the VA has, and, Doctor, you mentioned this about consults. I said this Monday night. This is really simple. We

had almost 100 percent, 95 percent of our consults that we saw kept their appointment.

Why? Because if I miss that appointment, that is a slot that wasn't filled. I didn't have any revenue. So we made sure that we contacted that patient over and over to be sure that they kept their appointment and came in. Almost all of them did.

If you mail a letter out two months ahead or three months and August, your appointment is August the 7th and then you don't ever check up, you should expect a huge number. And for someone in the VA, if you don't have anybody show up, that is a snow day. I mean, it is just free time. You are not doing anything.

And I have heard over and over and over again from my doctor friends who are at the VA that they do all kinds of things that ancillary people ought to be doing. And if you go to a private doctor's office, they are going to have those people calling to make the appointments, all of those things. Your time is focused on seeing patients and taking care of patients.

I think also something that is mentioned in this bill that absolutely has to change, there is no way on this earth that a veteran can go get a letter and do all of this and then go to my office and me do 1–800 hold. That is what it is going to be. And you are going to spend an hour and a half trying to get somebody in the office. The doctors are not going to see them. We can't afford to waste our time doing that. I mean, if we're able to see the patient, we ought to be able to do the care.

So that is something, Mr. Chairman, when we go to conference has to be changed or this will be a waste of time. I certainly don't mind the sunset. I think many laws ought to be sunsetted and relooked at after that length of time. I certainly appreciate your all's frank testimony. It is refreshing to hear someone from the outside not tell us how great everything is on the inside and we find out it is really a disaster on the inside.

And also, Mr. Collard, you mentioned something that I totally agree with. There are many hard-working, good, dedicated people working at VAs today. They are seeing veterans, taking great care of them. But there is a culture there that does need to be changed.

And I am going to stop and let you make any comments you want to.

Mr. MCCLAIN. Dr. Roe, I agree completely. I would like to make a comment regarding the no-show rate because Dr. McCaughey has mentioned it and you have mentioned it in a commercial setting as to how important that is.

And our experience, for five and a half years, we provided services under Project HERO which was a contract with the VA where we provided administrative services and we set the appointments.

We essentially would get the veteran on the line with the doctor's office and do a three-way conference call to set the appointment and then not only send a letter, but we would follow-up within 48 hours before the appointment to remind the veteran of the appointment plus the directions to the doctor's office. Our no-show rate in Project HERO was less than five percent.

Mr. ROE. Same as ours. I think you show right there, but that is a metric in the private world that you use because, again, your incentives are different in the private sector versus where you have

just a VA budget that you have this much money to spend at the end of the year and you spend it. If you don't, you send it back.

Mr. MCCLAIN. And that is exactly right. We were not compensated at all for a no show. I mean, that was not part of the contract. We knew that. But we were very diligent in getting the veterans to their appointment.

Mr. ROE. Thank you, Mr. Chairman. I yield back.

The *Chairman.* Thank you, Dr. Roe.

Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chair.

My first question is to Mr. McClain. I certainly agree with your assessment of the culture and, as you described it, personal gain over the veterans. And if we are really going to create a system that is truly veteran-centric, then I think certainly, I think we could all agree that we need to hear from the veterans.

And so my question is, are there any specific recommendations made by the VSOs at this time that you would actually endorse?

Mr. MCCLAIN. Ma'am, I am not familiar with all of the recommendations from the VSOs. I have not listened to all their testimony nor read their resolutions.

Ms. BROWNLEY. But in terms of, as you described, a great need for outside assessment of the organization before we begin to make any of the big changes that we need to make, you would include VSOs in that?

Mr. MCCLAIN. Oh, that is part of the voice of the veteran. They are a huge stakeholder. There isn't any question about it.

Ms. BROWNLEY. Thank you.

And, Mr. Collard, I certainly agree, I think we all probably agree of your assessment that the IT system for scheduling is archaic.

Are there systems out there that you would recommend?

Mr. COLLARD. Not a particular system, but just knowing that they are present and they are used. And if I could just extend upon an IT element or a pre-call or a post-call.

What we are really talking about is not fundamentally the reimbursement around or the productivity that is impacted like a snow day for a no show. What we are really talking about is that quality outcome again.

So if a pre-call is made and we know the veteran shows up fully prepared for the procedure or the treatment, they know where to come, they know when to come, that is going to drive quality.

The post-call efforts that are in place also, again, not just a unit of a box checked, but the empirical evidence on the private sector side that reduces readmissions improves medication compliance rate.

There was a study in the Annals of Internal Medicine about a year and a half ago that showed simply the proper education within the care setting and post-calls improved just the propensity to stop at Walgreens and CVS and fill the script.

And now, again, private sector example, but I think we all have to eventually come—we are doing a really good job today talking about the what and the how and we have always got to return to the why. And I think each of us have recognized the why of these conversations.

Ms. BROWNLEY. Thank you.

And, Mr. Collard, again, I mean, from your vantage point, I mean, how do you think we can better instill integrity into the VA management? And, I mean, how do we instill, you know, starting yesterday, starting today, how do we begin to instill a sense of urgency within the Veterans Health Administration?

Mr. COLLARD. As with any organization, urgency begins at the top. Accountability begins at the top. What we have to be able to do is narrow the focus. The one big idea, again, I would come back to Monday, this doesn't have to leave a committee and take on 50 things, but the one big idea that could create momentum and confidence in our veterans provide clear expectations out of that sense of urgency, out of an assessment that could be done, make sure that the training is adequate for those asked perhaps to do something new or do something differently, and then make sure that we just utilized methods of verification and validation like any other industry would do to ensure in real time that things are happening so that we don't find the fire storms that exist when either whistle blowers make a call or finally data reaches its peak.

Ms. BROWNLEY. Thank you.

And you, I think, in your testimony, you talked about, you know, big change with proven outcome solutions and that the VA is unique, but we can't be terminal about its uniqueness, that we have to look to better outcomes.

Mr. COLLARD. Uh-huh.

Ms. BROWNLEY. So is there anything about the VA medical system—I am not quite sure how to ask this because I agree with your assessment—but that is unique, that we don't have another place to look to for best practices?

Mr. COLLARD. I just think we have to get beyond that as the question that would be asked from internally. The single most improved hospital in the United States of America is Trinity Medical Center in Birmingham, Alabama. They are in a 40 to 50-year-old physical plant. They don't have any private rooms. They are all semi private.

They have a call light system. When it rings from the patient bed, it actually rings to the PBX operator of the hospital who has to then ring the nurses station and, yet, they decreased call light times in excess of 60 to 70 percent with the hand that is dealt them.

Ms. BROWNLEY. Thank you. I yield back.

The *Chairman.* Thank you, Ms. Brownley.

Mr. Flores, you are recognized for five minutes.

Mr. FLORES. Thank you, Mr. Chairman.

I thank all the witnesses for being here today.

Dr. McCaughey, thank you for the quick feedback on the Senate bill. That is very helpful.

Mr. Collard, one of the things I would ask you to do in future testimony is when you use the word standardize, be sure to say that that doesn't mean centralized because I think one of the issues we have got is that centralization sometimes cannot be the solution.

Mr. COLLARD. Uh-huh.

Mr. FLORES. Mr. McClain, you hit the nail on the head today. You said that we have a unique opportunity to reform the VA and

that if we don't do it well that we will be here again. And with that in mind, that generates my question.

I would like each of you to spend about 90 seconds telling me what the VA of the 21st century would look like and totally disregard what the VA is today. Disregard the people, the brick and mortar. Disregard everything. What does the VA of the 21st century look like? What does it have in terms of people, culture, systems, leadership, use of private sector resources? Is there a need for a union in the VA?

And so let's touch on that and I am down to actually about a minute for each of you. And I would really appreciate if you would provide some feedback in writing afterwards. I know you are doing this as volunteers, but you have the best interest of our veterans at heart. So if you could follow-up in writing, that would be awesome, but just a minute from each of you, and let's start with you, Mr. McClain.

Mr. MCCLAIN. Thank you, sir.

To put it in as few words as possible, I would say it has to be veteran-centric. In other words, you put the veteran in the middle and you build the system around. So you have teams in an integrated fashion providing care coordination and integrated care to the veteran.

And the metric is outcomes, health outcomes, how long did you extend the life of this particular veteran, how long did you extend the quality of life of this particular veteran, and right now we are not measuring any of that.

Mr. FLORES. Okay. Mr. Collard, you have about a minute.

Mr. COLLARD. I think it is the Veterans Healthcare Administration that has as one of its chief focal points the ability to reduce variance in all practices or in as many practices as can be. And what that can mean is the practice of access for our veterans, the practice of care, the practice of care environment for our physicians.

You know, in the private side, we joke that a physician typically works in four hospitals, the daytime hospital, the nighttime hospital, the weekend hospital, and the holiday hospital. And I can just imagine how many different versions there are in veterans' hospitals today.

So the ability to reduce that variance, to standardize those practices, and when identified as a true vetted best practice, the ability to move very quickly across the system to implement those best practices.

Mr. FLORES. Okay. Dr. McCaughey.

Ms. MCCAUGHEY. Yes. Let me point out, and I am very grateful to be here today, that your time is valuable, but time is also extremely valuable for these vets who are waiting, who are stuck in these waiting lists, 63,000 who waited a decade and never got a first appointment and now 57,000 who are currently waiting for their first appointment over 90 days.

So I would point out that this bill that you will be considering establishes two commissions, one to study the issue of VA construction, what has gone wrong, the delays, the cost overruns, and where construction is needed.

Mr. FLORES. I don't want to talk about legacy. I would just like to talk about the path forward.

Ms. MCCAUGHEY. I want to just make this point. Don't waste your time with another commission. In 2012, you had a commission do that. Read the report. I am sure that the new commission will find exactly what the commission found two years ago. They discussed Las Vegas, Denver, St. Louis, all the places that had those construction problems.

And, secondly, this bill calls for another commission to discuss staffing and healthcare needs, particularly the need for physicians. You had a study like that done two years ago in 2012. I urge you to read it. It will save you a lot of time if you want to fix this while the vets who are sick are waiting for care.

Mr. FLORES. Again, I would ask each of you to think about this, back out of the weeds a little bit and think about this from a 50,000 foot overview. What does the VA of the 21st century look like? If we could start all over again and not worry about any of the past sins or the postmortems or any of that crud, what does the VA of the 21st century look like?

And, again, I agree it should be veteran-centric. So if that is the vision, I want you guys to tell me what the structure is. And I don't have time for that. So if you could follow-up in writing, that would be awesome.

Thank you. I yield back.

The *Chairman.* Thank you very much, Mr. Flores.

Ms. Titus, you are recognized for five minutes.

Ms. TITUS. Thank you, Mr. Chairman.

Thank all of you for being here.

Over the past week, we have had a lot of discussion about how to integrate metrics into evaluating the system. We keep hearing metrics this, metrics that. And then just recently the VA said they are dropping the metric of 14 days as a way to measure the scheduling appointments because that was unrealistic. Now they have changed it to 30 days.

I know we can't abandon performance metrics. But when I talk to the people at the Las Vegas hospital and they go into all these details, then they tell me but this doesn't really measure what we are doing because it doesn't count the first appointment that they have when they come in on the very same day, so it is not an accurate reflection.

I wonder if we are not suffering from the ecological fallacy. We just can't see the forest for the trees.

Do you have some suggestion about how we better use metrics or we get rid of some metrics or how we can do evaluations better, anybody?

Mr. COLLARD. Yeah. You know, in our industry, we tend to be gluttons for punishment when it comes to metrics and I think it is important that we create a stop doing list. If you look at the Medicare value-based purchasing formula even itself just in the last couple of rounds is that there has been a decreased focus on process measures and a very much increased focus on outcomes measures.

So not that you give the aspirin with an acute MI in the ED because we have all gotten pretty good at that now.

Ms. TITUS. Uh-huh.

Mr. COLLARD. But how about mortality index? How about mortality rates? How about surgical site improvement initiatives there? So, again, narrowing the focus in a much fervent ship from process to outcomes.

Ms. MCCAUGHEY. I would like to second that. I fully agree with that. And, in fact, the article in the New England Journal of Medicine that the chairman referred to it in his opening remarks underscores how besieged, how suffocated doctors are by the requirements and there are so many metrics in the charts that you lose sight of the really important ones. And not only that, but you lose the doctor/patient relationship.

I am sure you have experienced this recently. You go to see your cardiologist, your internist and instead of having a face-to-face conversation, the doctor is there trying to get everything into the computer while you are in the office with him or her. So we need fewer metrics. We need outcomes measures instead of process measures.

And I would like to applaud those involved in formulating this bill and working with the VA to make their metrics transparent because for a long time, they have not made available to the public their outcomes measures much to the distress of all of us who wanted to see them.

Ms. TITUS. Thank you.

Mr. MCCLAIN. I think that the one thing I would say is that we have to obviously measure the right thing. There are a lot of things out there in Medicare that I think shows some quality outcomes, indicators of quality outcomes. And even though VA is a fairly unique system just by the way that it is structured, it is delivering healthcare just like a lot of other systems are delivering healthcare. And they shouldn't be afraid to take a look at those metrics from the outside.

Ms. TITUS. One other question. We keep feeling this push to send veterans out of the VA into the private sector for care wherever they can get doctors who may be available to them that aren't in the VA. And that is fine. But in areas like Las Vegas and some rural parts of the country, you have got a shortage of doctors. So pushing them out there on already overloaded doctors is not going to solve the problem.

I have got a bill working with some Members of this committee to create more residencies at VA hospitals in areas where there aren't enough doctors.

Do you think that is a good idea or do you have other ideas how we might address that?

Mr. MCCLAIN. I think that is one thing that you can do. Certainly there are several other things that we are currently looking at to discuss with VA in order to provide some solutions, especially in the rural health areas. Tele-health is a big one. There are perhaps mobile facilities that might go around to service some veterans.

There are a lot of different things. You can hire what are known as locums or locum doctors in a particular area to serve for a particular period of time. And there are some innovative solutions that I know VA is looking at, but they haven't pulled the trigger yet on some of it. And this may be the opportunity to do it.

Ms. TITUS. Doctor.

Ms. MCCAUGHEY. Yes. I was just going to add to that that most M.D.s in training at a teaching hospital do rounds at a VA, do some of their training at a VA hospital. It is just standard practice. And, of course, in rural areas, it is a bit different.

But I would change the use of one word you chose. We are not pushing them out of the VA. We are just allowing them out, giving them the choice if they wait so long or don't have another place, if they can't get an appointment at a convenient VA. So I don't think anybody in this room wants to push vets out of the VA or eliminate the VA.

Ms. TITUS. Well, my point is if they go out into the private sector, we need to have some doctors out there who are available to help them.

Ms. MCCAUGHEY. You are so right.

Ms. TITUS. And there are shortages of doctors and you have VA hospitals that might be a place where you could do additional residencies.

I yield back. Thank you, Mr. Chairman.

The *Chairman.* Thank you very much, Ms. Titus.

Mr. Runyan, you are recognized for five minutes.

Mr. RUNYAN. Thank you, Mr. Chairman.

Mr. McClain, it is some of your written testimony. Can you give me a couple metrics that the VA uses that are the most harmful?

Mr. MCCLAIN. Well, I think the most obvious was the 14 days. When you say harmful, I guess you are talking about harmful to healthcare delivery.

Mr. RUNYAN. Yes.

Mr. MCCLAIN. I would point to most of the metrics that just measure process and check a box rather than healthcare outcomes.

Mr. RUNYAN. Okay. And this is really for all of you to touch on. And I know it has been touched on and I just want to confirm it and have it on the record because I think, and we will start with Mr. Collard, I think you have said it a couple times here.

Some of the stuff, i.e healthcare record, the VA does very well. We have only scratched the surface on what this is. I chair the subcommittee on disability claims, so that is the next step. Okay?

Now we are tying in the private sector, the VA, and another government agency, the DoD that don't communicate very well.

Are there private sector platforms today that you could buy out of a box that could accomplish that?

Mr. COLLARD. Not that I am aware. And I think what we have to be able to do is if you look at the VA electronic health record, which, again, is hailed as cutting edge, clearly there is an architecture there that even the private sector could look towards for some learning.

The trouble in the private sector is you have a number of vendors that are positioning themselves as the most prolific electronic health record and what that does is that actually stifles the ability to communicate between private health systems.

So, again, it is an opportunity for us to look to the VA where there could be some good things going on and perhaps move from there. But on the private sector, it is probably as fragmented as can be.

Mr. RUNYAN. And, Chairman, I think it goes to what Mr. Johnson was saying the other night. They won't show us what their architecture is a lot of times, so no one could even build a system that could be even remotely compatible with it. It is part of the problem.

And really I just want to make this point and I am going to yield back my time because I want to let some other people. And I think we came to the conclusion also that we do this in government all the time. Continuing to throw money at a system that is broken structurally is not going to solve the problem. And I know you all agree with that. I just wanted to make that statement. Until we fix it, throwing money at it is going to do nothing but cause us to throw more money at it.

So with that, Chairman, I yield back.

The *Chairman.* Thank you very much.

Dr. Ruiz, you are recognized for five minutes.

Mr. RUIZ. Thank you, Mr. Chairman. I thank all of you for being here and giving your input to this very important topic.

There are some terminologies that have been said that are very important to me and the most important is to be veteran-centered, so be patient-centered, and I appreciate Dr. Roe's comments on that because as a physician, it is our life blood; it is what we live for; it is the outcome that we seek; it is to make sure our patients, we reduce their suffering and promote their wellness in whatever we do, and at that moment, our patient is our world and you are universe, and I believe that is the sentiment that we should have here in Congress, as well, with our constituents, but also in the VA with the whole apparatus focusing on that. And I believe that the urgency is very much needed and I believe that with the working in collaborations with the VA, this committee can make sure that this urgency is highlighted.

You mentioned also things that are very important, which is standardization, and I am familiar with that as an emergency medicine physician. You know, you come in with a patient and they don't know—you don't have any information. It is a multi-organ trauma or emergency, medical emergency, and you just have to figure it out. And the way we do is we have clinical guidelines and training after training after training after training to help us with the framework to treat that patient. And I believe that in standardizing the care with the VAs throughout the system is very important, but when I did my veterans initiative back home in the Coachella Valley in California's 36th District, some of my veterans there said they have to re-register and they have difficulties going from one VA to another VA, even if they, you know, are here for the summer or the winter break or whatnot.

So how do we create that interoperability within the VAs throughout the country?

Mr. COLLARD. I guess that is more of an IT question. I know that that has been a goal of VAs, that they haven't accomplished yesterday. I think that several years ago there was the VLER, the veteran lifetime electronic record, which was a composition of all of the VA benefits that a VA veteran could get in one place; in other words, you could go for your healthcare, but if you had a disability

claim, it would also be reflected, and if you had a VA home loan, it would be reflected.

I think that is still a great goal. I don't know where VA is along the timeline for doing that, but in just getting a single medical record where you do not have to re-enroll every time you go north or south or wherever you are going in the VA, I think has to be a goal that would really assist veterans across the board.

Mr. RUIZ. Wonderful. And the next question, Mr. Collard, is we talked just now about the difficulties of communication and sharing of that information have one VA hospital to another, but how about the communication structures with non-VA providers with the VA? And we know that there are some barriers to doing that, and what can we do to minimize the barriers so that the family doc in a rural area, if there aren't enough physicians, can receive the information from the VA that they need to provide the continuity of care that the veterans need, but also provide those same standards of reporting to the VA so that they can enter that information into their outcomes measurements that they need for the patient?

Mr. COLLARD. So being as far from an IT expert on the panel today, I would say that what Mr. McClain has referenced before in terms of a more open-source environment within the VA's system itself.

Let me go off the answer for just a little bit because a lot of this also has to do with the manner with which a veteran is received at a different facility, and let us just call it first impressions. If I go from the veteran to the person on the other side of the desk as well, I think many of us have, whether it is at an airline counter, whether it is at a hospital, an emergency room, sometimes, we get an impression that the person on the other side of the counter doesn't have quite the empathy that they would need to project to a veteran. I think we have to even be able to—this is a little bit of a hearts and minds conversation here, as well, and, again, it is off the IT perspective, but I think the ability to create a sense of openness and welcome and first impressions for those veterans is also key.

Mr. RUIZ. Thank you. I have run out of time.

I yield back whatever I had.

The *Chairman.* Thank you very much.

Dr. Benishek, you are recognized.

Mr. BENISHEK. Thank you, Mr. Chairman.

Well, I really appreciate your testimony this morning, and I completely agree with you that we cannot waste this opportunity to revamp the entire VA system, because as I think you said, Mr. McClain, we will be back here once again. You know, I was just looking at the VA Health Administration organizational chart and what is it going to take? I mean do we have to get a—arrange for a bidding for some off-site consultants to tell the VA how to reorganize itself because, obviously, I don't believe that they can reorganize themselves.

Mr. Matkovsky, the assistant deputy undersecretary was here on Monday. She seemed to think that a few fixes here and there in the system is going to make everything hunky dory, and I completely agree with, I think all of you, as far as the whole system needs to be re-evaluated and a structure of management put in

place that allows more communication between the management and the people that actually deliver care.

You know, as a physician, I worked at the VA. I, by the way, don't think that the health record is all that great, but it is often better than many other health records. We need to have better communication between, I feel, like the physicians who actually take care of patients and the top management because often, physicians are put in circumstances that waste their time, are bad for patients and don't get things done in an efficient manner.

So how do we make that happen? Can you maybe give me some more ideas that expand upon what you said before? Maybe each of you could take a minute of this and tell me how, as Congress, how can we make this happen to the VA to change the entire structure so it is much more efficient?

Mr. MCCLAIN. Doctor, I would start off with contracting with people who are expert in organizational design. There are companies out there that that is exactly what they do. It is a skill; it is an expertise. And I really wouldn't expect VA to be able to determine exactly what that next organization should be because that is not their expertise. But there are companies that that is all they do, and they do it very well, so that is where I would start to look.

Mr. BENISHEK. All right.

Mr. Collard?

Mr. COLLARD. If I could extend Mr. McClain's comments. We can assess all day along, but the real question is once the assessment is completed and recommendations are given, is will there be execution on those recommendations? And with the number of physicians we have on the panel, let's just use two glaring examples. We used aspirin with acute MI earlier. It is probably a pretty successful metric across the United States, but then let's talk about hand washing.

We have been talking about hand washing for as many centuries as there are medicine, essentially, out there and for some reason, we have not gotten good at hand washing. The difference between one metric like aspirin with an acute MI and hand washing is we just tend to continue to talk about it, and those organizations that find a way to put the structure in place for clear expectations, execution, verification, and validation of those organizations that find themselves the ability to reduce infections by just improving something as common sense, uncommonly practiced as hand washing.

Ms. MCCAUGHEY. Now you are really close to my heart. But I would say in addition to looking at the top-down structure, and we know that leadership is important from the top, spend more time listening to what the doctors in the VA say. Here is what I hear: They are very frustrated when they see a patient and they said, I would like to see this patient again in 30 days, right, and then all that malarkey goes on and they never see that patient again. The patient never gets an appointment with that doctor again. There is not enough continuity of care with the same physician.

And when Dr. Ruiz said before this has to be patient-centered, it really has got to be patient-centered. It really has got to be the doctor-patient relationship. That is what is being lost in this huge bureaucracy and we really have to make sure that that is protected

because that is, in essence, what is going to make these vets better; that is what is going to save their lives.

So, in addition to looking at the top-down structure, I would really make sure that you are talking to the physicians who are working inside the organization.

Mr. BENISHEK. Oh, I don't disagree with you at all. I mean as a physician that worked there, I was very frustrated with the fact that ideas that I had, you know, just weren't taken up or dismissed because they were my ideas and they weren't coming from the management, and that would just need to be fixed by this basic restructuring of the entire system.

I am out of time. Thank you.

The *Chairman.* Thank you, Doctor.

Ms. Negrete McLeod, you are recognized for five minutes. Ms. *Negrete McLeod.* Okay. Thank you, Mr. Chair.

I have found out that the VA audit of Loma Linda which is, we actually have three members on this committee that, while it is not directly—four—okay, four, Mr. Cook. We have four members that it doesn't sit right in our district, but all of our people around it is where they focused their care at. It has—right now, current patients only have to wait four days for rescheduling of an appointment. New patients have to wait an average of 43 days for primary care, and appointments, 50 days for specialty care, and only 28 days for mental health care. Loma Linda has the lowest wait time for mental health care in Southern California.

And coming as a Kaiser member for 42 years myself, I remember when I first joined Kaiser people used to say, Oh, you are a Kaiser member. Now people say, Oh, you are a Kaiser member. So, you know, being there, I have seen the evolvement of Kaiser from those kinds of negative remarks to those kinds of really favorable remarks because Kaiser has evolved—in California at least, I don't know about other states—but that is the plan that everybody wants to emulate because they have got all of their stuff together. Their medical records are on-time. Their everything—I have had the same physician for 30 years, so I get to see my own physician. So I don't know why the VA couldn't emulate something like Kaiser.

And while now we have had tons of hearings of what is wrong with the system, we as a policy committee—and there are a whole lot of physicians on here—we are the policy committee; we should find out how we fix it and then all of our focus should be on how we fix it and no more about incrimination. But let's move forward as the Nation's policy committee on this particular issue. Thank you.

The *Chairman.* Thank you very much.

Mr. Huelskamp, you are recognized for five minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

A couple follow-up questions on some of the comments that were made. In particular, Mr. McClain, and Mr. Collard, your companies have apparently either operated multiple facilities or oversaw those or looked closely at those in reports. Have you found any other health system in this country that is similarly situated—so poorly situated as the VA is today? I guess, start with Mr. Collard whose company has done many, many, many of those examinations.

Mr. COLLARD. Sure. You know, the first ones that come to mind would be organizations that might even look a lot like the VA, the safety net hospitals, so organizations that are typically, perhaps inner-city, serve a particularly disadvantaged patient population, they typically tend to be trauma centers. They tend to have all the right reasons not to succeed, and yet those are the organizations that we can show time and time and time again, when decisions are made, when strong leadership leading with good cultures around alignment and accountability succeed, which, again, just causes the question, why couldn't we emulate that within——

Mr. HUELSKAMP. Well, I am looking for—I am trying to determine how bad off the system is. But when you say that if we just did a good review and look closely, we would have a whole culture of non-accountability. And so if you make a bunch of recommendations and we have got stacks and stacks and stacks of them, the doctor mentioned those, I mean tell me how you would implement those. So what is another study if you have leadership or if that is not a very descriptive term in my opinion of what is going on. How do you actually handle that?

We know what the answers are; the doctor mentioned that. We need to put the veterans back in the driver's seat. Get the administrators out of the way, let them see their doctors, whether they want to do it in a clinic, in a hospital, or elsewhere. So how would you implement that?

Mr. McClain, how would you implement in suggested reforms? I think we know what we need to do, but nobody's done it.

Mr. MCCLAIN. Well, it is very difficult. Anyone that has done any sort of change management realizes that trying to do it from the inside is very difficult. So I would think that some company that specializes in this to assist VA in making the change to the veteran-centric system, I think, would be a good investment for VA.

Mr. HUELSKAMP. And, Mr. McClain, I understand your company, if I read it correctly, operates a number of TRICARE facilities?

Mr. MCCLAIN. We are, in my segment of VA, we have the TRICARE south region, and so we are the manage care support contractor for TRICARE. We have 3.2 million beneficiaries in the south.

Mr. HUELSKAMP. If a TRICARE subscriber, customer, whatever you call them, doesn't like the care that they are getting, what do they do?

Mr. MCCLAIN. Well, we are an administrative services organization for TRICARE; in other words, we maintain a network of providers and specialists for the TRICARE beneficiaries and we also have a patient advocate. And if they don't like the care that they are providing, they can come back to us and we can try and resolve the issue for them.

Mr. HUELSKAMP. Do they have to get permission from the facility you have assigned them to?

Mr. MCCLAIN. No.

Mr. HUELSKAMP. So they actually have a choice?

Mr. MCCLAIN. Yes, they can——

Mr. HUELSKAMP. Well, very good. I think the VA might learn from that, as well.

One thing, Doctor, I would like to hear from—one question on the union rules that she would provide to us. I had heard some stories about that. I would like to look at those later, but a follow-up comment——

Ms. MCCAUGHEY. They make good reading.

Let me just point out your very interesting question, however. Competition usually provision improvement, and if we develop some avenue that provides broader choice for vets on where they receive care, not dismantling the VA by any means, but whether it is a Medigap card just for VAs or for older vets, whatever it is to give more vets a choice, right. You hear on the radio and on the television, you see the hospitals advertising, come to our hospital, we have the best care, right? The cleanest rooms, whatever it is.

The VA doesn't have to do that. But their budget every year is dependent on how many vets are enrolled in that system. It is absolutely, by statute, dependent on that. So they don't want to see their vets going other places for care. Competition will improve the system.

Mr. HUELSKAMP. Yeah, that would be great to see the VA having to advertise and actually—I would argue that their budget is not dependent on their standard of care. What I think we have determined here in the last few months is that there is a standard of care, it is just ridiculously low.

Ms. MCCAUGHEY. Although some VA hospitals are quite good. There are some that are really good; they have great leaders and——

Mr. HUELSKAMP. But the veterans, and I could believe that, but we have 70 criminal investigations going on right now. So as a member of Congress and awaiting data, the data has been tampered with. It is hard to accept anything from the VA because the data has been falsified and we are hearing that again and again.

Thank you, Mr. Chairman. I yield back.

The *Chairman.* Thank you, Mr. Huelskamp.

Ms. Kuster, you are recognized for five minutes.

Ms. KUSTER. Thank you, Mr. Chairman. Thank you for all being here with us today.

And I share your concerns that came out of the VA OIG report. It does seem that the VHA has lost its focus on the primary mission of safe, quality care for our veterans.

I want to focus in on this discussion about competition and get at the notion of veterans having choice because in my district, I have—I meet with veterans every time I go home, and just recently around these issues we had a veterans round table to talk about the quality of care in New Hampshire. My veterans go to Manchester to our veterans health center and also to White River Junction on the border have Vermont.

And the question that came up was the one that you raised about going outside of the network. I was presuming that that was a logical conclusion, but the veterans that I actually spoke with want to have their care at the veterans facility. They feel more comfortable there. They feel that they are going to be better understood there.

So my question is how—and I like this idea of the Medigap card, I am interested in that. Beyond that, how can you use—and let's

just start with you, Mr. McClain—about the TRICARE when you are working with that network, what are the wait times there for someone who seeks an additional appointment?

Mr. MCCLAIN. Depending on what the specialty is or what the follow-up is, we can get them in within 30 days.

Ms. KUSTER. And that is actually very similar to what it is in New Hampshire in the veterans system. I guess my question is: Are there things that we could be doing with the facilities in terms of one of the issues was about residencies brought up with Representative Titus. Are there other ancillary care providers? Is there something that you do in the private sector that we could be doing with nurse practitioners or people—other—because I agree with you that we need to focus on that relationship with the patient and their healthcare provider.

Can you give us examples of what we could be doing from the private sector, and maybe, Mr. Collard, you have a suggestion on that?

Mr. COLLARD. Sure. A couple of quick fixes that have been mentioned in numerous testimonies is just the ability to recruit at a more rapid pace, mid-level providers. If you take a look at the private sector folks whose names typically make the headlines, every single one of those folks today are talking about access to care. It is not a different issue. And one of the ways they accomplish improved access to care is through the provision of mid-level providers is that first wave of patient interaction and it just, again, seems to work. The outcomes tend to be there.

Ms. KUSTER. Do you think it would makes a difference to have a policy of alleviating debt for people who come out of medical school or other schools for healthcare providers that they serve within the veterans system and we would alleviate that debt, do you think that that would make a difference?

Mr. COLLARD. It has already been proven to work. Having operated hospitals in some of the most medically underserved counties in the United States, mostly the southeast United States, you know, we already have programs when residents will come and agree to practice in rural or underserved areas; that is a proven program. And I think this is no more—no less noble of a cause, than for these veterans.

Ms. KUSTER. And would certainly describe my district in the rural parts of the north country. I am very pleased by the way that we were working hard to get increased access to telemedicine for vets who have to travel in bad weather, mountains, such. But we were also successful in—we will be opening two health clinics in Berlin and Colebrook in the northern parts of my district.

I want to focus in on this issue about hiring because one of the most troublesome things I have heard about the VHA has to do with how positions are filled and there is not a priority to clinic positions. I was shocked by that, that the leadership can make a decision about filling administrative position. How can a surgery team operate and function at a high, efficient level if they lose a nurse and that position isn't filled?

What is your comment, for any on the panel, about the way positions are filled within the VHA and how can we do better and what is a policy that—and this is the most bipartisan committee in the

entire Congress, and trust me, we know a lot about substitutions that do not function well—but we can function together. Help us understand the policy that we could change about putting a priority on those clinical positions that are on the front line in filling those first.

Mr. COLLARD. So two quick things. I think it indicates the danger of levels of bureaucracy. The second point is behavior follows incentive, and so I bet if we look at how folks are driven for performance reviews, et cetera, you would find, perhaps, not a disconnect between the ability to fill an administrative position versus the ability to fill a clinical position.

Ms. KUSTER. And if we focus on those outcome measures, rather than these process measures?

Mr. COLLARD. Well, the outcome is getting the physicians the mid-levels and the frontline caregivers in place is the outcome.

Ms. KUSTER. Right. Well, I mean if the outcome is good results, you are going to need to have those positions filled.

Mr. COLLARD. Yeah.

Ms. MCCAUGHEY. I just wanted to point out that the report that was presented in 2012 deals specifically with this issue of assessing how many physicians are needed and who makes the decisions to hire them. I have it in my purse and I am going to give it to you at the end of the session because I think you will find a lot of the answers in there.

Ms. KUSTER. And the other point I wanted to make is that there is no other state that has been shortchanged more about VA facilities than New Hampshire and there are so many vets in New Hampshire who ride way over a hundred miles to go to a VA hospital in Boston or in White River because there is really no acute care hospital for VAs in the state and that needs to change. Whatever positions you make about constructing another hospital, New Hampshire should be near the top of the list.

Well, I am pleased to report to you that the surgery is going to be resumed in Manchester, and I used to think that a hundred miles was a long way until I met my colleague, Beto O'Rourke, who told me that his veterans travel ten hours to get to any type of facility. So we—although we have a great deal of discussion about being the only state in the country that does not have a full-service hospital, we are very, very fortunate that the two hospitals that serves our veterans are very high-quality.

Ms. MCCAUGHEY. Yes.

Ms. KUSTER. We do have an issue about people going to Boston, but I am well past my time.

The *Chairman.* Thank you very much.

Mr. Coffman, she just ate half your time.

You are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman, and thank you for yielding to me.

I have got a question. I am intrigued by this notion of this Medigap policy. First of all, refresh me, I become eligible for TRICARE next year when I reach age 60, and I think for—as a reserve military retiree, and I think when I will be 65 then, I go on to Medicare, and then does TRICARE then pay for a supplemental? How does it work for military retirees?

Mr. MCCLAIN. TRICARE for Life, that is the program when a military retiree reaches age 65, becomes a Medicare fee-for-service patient. So there is no more TRICARE Prime, TRICARE Extra or whatever; it is a—you are a Medicare fee-for-service patient, but you do have a TRICARE wraparound. So, really, it is one of the richest programs out there for Medicare.

Ms. MCCAUGHEY. But, of course, most vets aren't eligible for TRICARE.

Mr. COFFMAN. So tell me about how your—the system that you are advocating here today——

Ms. MCCAUGHEY. Yes.

Mr. COFFMAN. —and then, Mr. Collard, I would also like for you to reflect on it. So tell me how——

Ms. MCCAUGHEY. So this is a simple proposal. As I pointed out, almost half of the vets using the VA are on Medicare; they have 65 and older. They are virtually all covered by Medicare, but the out-of-pocket expenses under Medicare are too much for many of them, and so they continue to get care at the VA, even when they have an age-related problem like they need a bypass surgery and there is a teaching hospital down the street where they could be getting the care, but they are worried about not so much the any-one patient deductible, but the outpatient deductibles and copays. And so if we gave them a Medigap card just for vets, a special red, white and blue one to pick up those out-of-pocket expenses, then they would have the choice of going to another type of hospital for that care.

If you look at the outcomes measures, particularly for these age-related procedures, with the exception of just a couple of the VA hospitals, other teaching hospitals are producing better survival rates, so we would get a twofer. We would get the care for the vet. It is budget-neural, because it is all coming out of federal dollars, and they would have a better chance of surviving their procedure.

Mr. COFFMAN. Mr. Collard, my two colleagues at the table are much more resident experts on the notion of payor sources and what the structure looks like. I want to come back to the choice issue a while ago. There is a demonstration project underway as a structure for those of you who would be familiar with the Captain James Lovell Federal Health Center in Chicago which is one of the first demonstrations of the ability to combine veterans health with active military health.

And I remember one of the very first conversations that I was part of two years ago, and interestingly enough, the leaders of the Lovell Federal Health Care Center were less worried about the veterans being forced to come there and more about the veterans having the choice to go to Advocate Health Care, at the time, Provena Health Care, et cetera. So I think there is another opportunity for us to look within the industry and, perhaps, I couldn't say what their results are today, but this was a conversation two years ago where federal health care leaders were already focused on this notion of patient choices.

Mr. COLLARD. Well, I just want to say that I want to preserve the system right now until we fix the VA by whatever means. We, right now, are keeping our wounded coming back from Afghanistan out of the VA system by virtue that they do the rehabilitation on

active duty, unlike those who came home from Vietnam who were stabilized from the military system and then sent home to the VA, and our morale of our wounded is much higher, particularly on the military system.

Mr. COFFMAN. Mr. McClain, can you comment on this notion of providing this supplemental—to paying for a supplemental to Social Security to where there are not any copayments, so whereby veterans, 65 and older, who meet the income qualifications for care for have service-connected issues would qualify?

Mr. MCCLAIN. I think that it could be a part of the solution. You are really talking about funding here. You are talking about appropriations, as to what bucket it comes out of. There have been a lot of discussions over the years about Medicare—as to whether VA can be reimbursed by Medicare, and, you know, the answer so far has been no. So it would take some significant legislation for that to occur.

Mr. COFFMAN. I do want to make a point—I know that we are short on time—but one of the things that baffles me about some of the waiting lists—now, I certainly get the fact that if the veteran wants to go to the VA for care, we need to honor that, as long as he or she understands that this is going to be a little bit of a wait, that is great. But there were so many other means that some of these waiting lists could be taken care of by sending it out to fee-based care; sending it out under a contract; sending it out to an affiliate; sending it to a CBOC. I mean there are a lot of different ways that this could have been handled, and for some reason, which I haven't heard anybody talk about yet, is I'm not sure why those other sources of care were not used.

Thank you, Mr. Chairman. I yield back.

The *Chairman.* I can tell you why they didn't want to use it, because the VA thinks it is their money and they don't want to relinquish it. The problem with that is that money belongs to the veteran, and instead of saying we took an $8-million dollar hit for non-VA care to their budget, they need to say we took and gave $8 million dollars to the veteran.

Mr. O'Rourke, you are recognized for five minutes.

Mr. *O'Rourke.* Thank you, Mr. Chairman.

And to add to the point that Dr. Roe had made earlier and Mr. McClain had made about the success that hospitals and health organizations have in reminding patients of their visits, in the midst of this hearing, I got a text telling me that my appointment on Monday, June 16th with Dr. Rizik is at 9:00 a.m. to confirm. Hit C and reply on the text or hit C, confirm the appointment. It gave me a phone number to call up if I had any questions. So we know that those systems are out there, and not to beat the horse any more, but let's get that done. It works.

And Mr. Chairman, I would like to thank you and the ranking member who is currently not here, but you all on this committee have done such a great job in responding to this crisis, and I just think showing excellent leadership. We have heard from the VA directly. We have heard from the GAO, the Office of the Inspector General. We are hearing from the private sector. I think each of us in our individual capacities are listening to the veterans in our communities, but I would just ask that we have a panel of veterans

in veteran service organizations. If we are talking about veteran-centric care and basing this on the needs of the veterans that we serve, I think we need to hear from them. And add to Mr. McClain's excellent suggestion of having a management organization identify structural and organizational weakness, and complement that with the veterans and what they are missing in their care right now. And I think that one of the issues that has to be included in that review is the issue of accountability, and we have talked about it and described our frustrations with the amount of money that has been authorized and appropriated and virtually lost within that system and not making its way to those veterans, and I think that really is an issue of accountability, and we see it throughout the performance of the VA.

An issue that I would like to get your thoughts on, and I really loved Ms. Titus' idea about getting more residencies in rural or hard-to-serve communities like ours, is this question of where are we going to get the doctors in the capacity that we need? Already in El Paso, which as my colleague mentioned, is about a ten-hour roundtrip drive from the nearest VHA hospital—we do have a VA clinic, but we do not have a hospital—our patient-to-doctor ratio is on par with Syria or Panama. It is a developing country's doctor-to-patient ratio. We are having a hard time already throughout the country, especially in areas like El Paso. So I like the idea of more incentives and ways to attract doctors and providers to our community.

But when I meet with doctors, to your excellent suggestion of listening to the providers, they complain of having to perform functions that could much better be done by clerical staff. One provider, one doctor told me that he actually had to write out a prescription for a veteran to be picked up by a van, taken to the Greyhound station where he then boards a bus to go to Albuquerque, New Mexico, five hours upstream on the Rio Grande, and then to return. He said, Why can't somebody else do that? Why am I having to perform that? So I would love to get each of your comments and thoughts about how we do more to support the current providers we already have, who, by the way, I think are doing an excellent job.

I do spot inspections in the parking lot of our VHA clinic and talk to veterans leaving. I have not heard from a veteran yet who told me that they had a bad experience. They feel like they are treated like kings and queens, princes and princesses by the providers there. They have nothing but good things to say. What can we do to better support those providers and maybe 20 seconds down the line starting with Mr. McClain?

Mr. MCCLAIN. I think, once again, you could bring in some people that really understand process re-engineering and re-engineer that process. There are a lot of things that a doctor does not have to do and it is still within the standard of care, that could easily be done by a physician's assistant or an RN or an LPN.

Mr. COLLARD. You begin by that voice of the provider. Because you have to make sure that none of this testimony sounds like we demonize the providers and those folks that are right there on the front lines. Secondly, the ability to remove the non-value added

work steps that those providers are going through today, and this is not unique to any industry.

Ms. MCCAUGHEY. And thirdly, in section 301 of this bill there are two provisions that will make it more difficult for doctors, civilian doctors to provide the care that a vet is asking for with the choice card. So I would hope that you read those two passages—it is about like page 24—read those two passages and see if you can alleviate some of that paperwork burden that the civilian doctor would face if he agreed to treat that veteran.

Mr. *O'Rourke.* Thank you. Thank you.

Mr. Chair, I yield back.

The *Chairman.* Thank you very much.

For the Committee's knowledge, our intent is to have a single hearing in a couple of weeks with just the VSOs, to not have them in these hearings, but to give them the entire hearing to be able to look at all of the testimony that has been provided. They obviously are the stakeholders in all of this.

Dr. Wenstrup, you are recommended for five minutes.

Mr. WENSTRUP. Thank you, Mr. Chairman.

I can't tell you how grateful I am for this day to have arrived, and unfortunately it took disastrous findings within the VA to get to this point and it is a step in the right direction. I can tell you as a physician I am face-to-face asked Secretary Shinseki three times if I could go in with a team into the VAs and into the ORs and discuss where the inefficiencies are and how we could do things better and every time I was told, Yeah, we will do that. It never happened.

But I am encouraged because right before all this broke, we set up a meeting with the four doctors who are on this committee, bipartisan, with several of the administrators with the VA to talk about efficiency and access to care and quality of care. And, you know, there is a difference in different systems, right, if you have a system where many people that work there are saying, It is not my job; that is a problem.

And what you have mentioned many times today, I couldn't agree with me, and that is the physician input. If they can have the input of how things can be better, you have got to go that route.

And the other difference is the difference in responsibility in private practice and in other settings, which sometimes the VA, if I had a patient that missed an appointment, I want to know why, and also if they were post-op or whatever, I would tell them, they have got to be here. I have got to see them; it is my responsibility. And that tends to be missed if you don't know who is coming or going.

And measures such as standard of care are great. Obviously we need to do that, but if you are seeing one patient a day and giving outstanding care, it doesn't mean very much. And you also have to look at the access to care and the efficiency of operations. And so what you are saying today, I think is spot on.

The problem I have found within the VA system is you had too many people who don't know what they don't know because they have always been in that system. So they have never seen anything different, so they think that they are doing something great, but

they don't know that others are doing it much better, and that is where we need the outside input and the best practices.

We are hearing a lot of the same things here today, and I think that is great. Ronald Reagan once said if you have a message that is important, tell it over and over again, and to me, the best practices and efficiencies are driven by choice, which we have heard so many times today. When a patient is a liability, rather than an asset, we have a problem.

And patients need to have choice because for me, my level of success and how well I was doing is by how many wanted to see me when they know they have a choice, and that is really where we need to be driven.

It was mentioned before, too, you know, the ACA and throughout, we are really not addressing the doctor shortage. Because if you don't have providers—and not just doctors, it could be nurses, PAs, et cetera—you need to address those shortages in our country, and often times in the rural areas especially. So those are the other things that we needed to focus on.

I am pleased right now that the door is open for change and everybody here is open for change because I didn't know this day would come, and again, I am sorry that it took what it took to get to this day, but we have got to drive on. I like what Mr. Walz says, let's get the big idea out there and we can do that.

One thing I found interesting several months ago is I asked Dr. Petzel, I said, If the VA system were reimbursed at 105 percent of Medicare rates, would you be in the black? And he said yes. Some of the doctors on this committee politely disagreed that they would be able to pay their bills and be in the black with the system that they are running.

From your observations, what is your opinion on that?

Mr. MCCLAIN. I really don't have any data. I have not looked at that. I have no idea.

Mr. COLLARD. Lift up the hood on the question. When you compare yourself to yourself there is probably not a lot of accuracy that you can get. So when you take a look at those organizations in the VA that actually do submit data to the publicly reported databases, you have a way of measuring against others, and it is not a private sector versus public sector conversation. But when we continue to, whether it is patient perception—they use a tool called SHEP versus HCAHPS that you would see in the private sector—when you see that those two simply don't submit the data, the outcomes data that we talk about, we are actually stuck in this vicious cycle of, as you said, you don't know what you don't know, because you are comparing yourself only to yourself. It would be like taking a blood pressure of a patient without any gradations on the blood pressure cuff; you are just kind of guessing, well, it is that high.

Ms. MCCAUGHEY. I would like to address that question, too. According to MedPAC, Medicare used to pay ninety two cents for every dollar delivered. After the Affordable Care Act, they are now paying less than that.

And the reason that I raise that is one provision of the bill that you are going to be considering this week says that civilian doctors who take the choice card will be paying not more than the Medicare rate. So it is important to alert everyone to what you are prob-

ably heard from your constituents back home, that finding a doctor who takes Medicare is getting harder and harder.

The *Chairman.* Thank you very much, Doctor.

Thank you, Mr. Walz. You are recognized for five minutes.

Mr. WALZ. Thank you, Mr. Chairman, and thank you for being here today. And I think Dr. Wenstrup, and you heard it again, are hitting on this and getting there, and the care for our veterans is our top priority.

Mr. Collard, I thought you brought up some really great points, and I see the books you have there, and I always think in our office we—every new employee reads good to great and we talk about this idea of organizational design and system performance and trying to get there. And I—this was a description of a high-performing medical institution, multi-disciplinary teamwork, physician-led governments, and patient-centered culture. Is it about that simple?

Now, they followed up—this is Commonwealth—they followed up—I don't want to bait you on this. They followed up like this, information continuity, care coordination and transition, system accountability, peer review and teamwork for high-value care, continuous innovation, easy access to appropriate care, with multiple entrances into the system. That is where they went on with.

Mr. COLLARD. The data that I have shared with you today comes 100 percent from the Commonwealth fund site, whynotthebest.org, so I would consider it, and at the risk of being oversimplified, yes.

Mr. WALZ. Very good.

Mr. McClain, do you agree that you see that?

Mr. MCCLAIN. I don't have any comments.

Mr. WALZ. And I bring this up because we have got to believe that we see this, and it is not as if Jim Collins is all of a sudden the VA just—they have read it. They have seen it and everything, and what I am trying to get at is how do we incentivize that? Dr. Wenstrup brings it up. I think we all agree with that on how we try to get there. There is, first and foremost, the care of veterans, but there is a cost factor that figures into this and how, when we do this big idea—because I do believe this, I believe if we get this wrong now, we are going to set the care for veterans to the next two decades going to be very, very difficult to change. So this is an opportunity, but it must be thought out and it must be right. It must not be driven by ideology.

And Mr. Collard, your position on it, this is not the issue—if you simplify this into the public versus the private sector, we are going to go down a road that is going to look just like this. I would guarantee that.

So I thought about this: Why do you think this never went into the scheduling because is, again, Commonwealth, and we have seen it in practice in hospitals. Patient scheduling system uses algorithms to assign new patients to physicians and orchestrate a patient's time at the clinic. It takes into account the patient's availability, the specific time and sequencing requirements of office consultation, laboratory test procedures, and the travel time between appointments.

If you have ever been in a medical institution that does this, you leave with a sense of wonder that they were there to move you

from place to place. Is this a cultural barrier of why this wasn't implemented at the beginning?

Mr. COLLARD. Yeah, one of the issues we haven't spoken about is just that, the notion of patient flow. So the whether it is flowing a patient through a site facility or through a series of recommendations and consults through different facilities, part of this is, again, the efficiency of patient flow, which, again, is probably a whole other hearing.

Mr. WALZ. When we do this, and we are going to have to get human nature in this, incentivized and disincentivized behavior, oversight and everything else that goes into this, Dr. McCaughey, this goes back to you and the work, and I see this, of course, representing the district that the Mayo Clinic is in. Hospital acquired infections are a huge issue, a hundred thousand Americans die by these every year; they are huge.

Now, it is incentivized on this that hospitals who don't get a handle on this and bring it down are going to be penalized in reimbursements from Medicare. Does that makes sense?

Mr. COLLARD. Well, it makes absolute sense, and the data beneath those incentives and outcomes with which are just irrefutable. If you take a look at a patient's perception of a hospital's responsiveness while the patient is in the hospital, there is almost a linear correlation between the patient's perception—we get hung up on that sometimes, well, it is just perception, how does the patient know how really good we are? And yet when you pull the data from the CMS Web site across 3900 facilities you see a linear correlation between patient's perception and the actual cases per thousand patient days of vascular catheter associated infections, Stage III, Stage IV pressure ulcers and poor glycemic controls.

Mr. WALZ. I was just on that site today. Why do you think it took us so long for the private sector to be willing to put that information up?

Mr. COLLARD. Well, actually, it is our own kind of perversion to the data. When you go to the CMS Web site you take a fork in the road. You either go to the experience or you go to the quality, and, in fact, it is the very same dataset. So when you pull the entire dataset and begin looking at those correlations, it is actually right there in front of our eyes.

Mr. WALZ. How do we meld VA's experiences into that because it does seem like we are on two parallel realities here on reporting and experiences and things like that. What would be your suggestion on how those two are melded?

Mr. COLLARD. Well, we won't suffer from a shortage of data, that is for sure. It is a matter of how we bring the data together. So it is the ability to bring some organizations—if you go on the Commonwealth funds site today, you'll actually be able to pull 83 or 84 VA hospitals that actually submit that data.

Mr. WALZ. That's right. That is what I was just able to do.

Mr. COLLARD. And I just ran the custom report prior to the hearing to make sure that we had a good current sense, but that is only 83 or 84 of the VA hospitals. Where are the others and how could we then get away from this comparing ourselves to ourselves?

Mr. WALZ. So the solution is out there. The will of the American people to get it, and now it is a matter of getting it in place, is that your——

Mr. COLLARD. You bet. And we have the guiding coalition around this table and the VA and with folks who have MD and DO on their name badges, physicians or scientists, and the scientists, they are driven by good, credible data, not anecdote. So we have to work both on this committee, as well as our physicians within the VA that could lead to these kinds of answers.

Mr. WALZ. Very good.

I yield back. Thank you.

The *Chairman.* Thank you very much.

Ms. Walorski, you are recognized for five minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman, and Ranking Member Michaud.

I am grateful, as well as most of the members here—that you have heard from that have been here today—because I really feel like we have a copilot now and the solution is there and we can see light at the end of the tunnel, and it has been a very, very dark story. And I don't have questions, I just wanted to thank you for being here.

I wanted to echo what Mr. Walz just said that I think you can see the relief in this room around most of this place today that the solutions are there, and I would agree with Mr. Walz, the attention of the American people is on this, and the continuing drive by the American people to continue to seek out the absolute best solution, the big idea, the step forward, and I think that many of us today see light at the end of the tunnel. And I am grateful, you know, when we saw the story getting darker and darker and 69 criminal investigations and the kinds of things that are happening, I think most of us—because we talk about it outside of this committee—knew that there are solutions there. There are best practices there. There are private sector and private industry folks that certainly are here to come alongside and guide this into the kind of success that we know the VA can be.

So I just wanted to add my comments that you coming today and just broadening the light here for us to be able to see how it can work and give us something to shoot for as a jurisdiction of oversight continues is the most welcome news, I think, that I have seen since we got into this whole situation. So on behalf of the veterans in my district, we are grateful, because I do see light at the end of the tunnel.

Mr. Chairman, I want to thank you for your leadership and Mr. Michaud, as well. I will yield back my time.

The *Chairman.* Thank you very much.

Ms. Brown, you are recognized for five minutes.

Ms. BROWN. Thank you, Mr. Chairman.

First of all, let me say that I want to thank the veterans that work in the VA hospitals for their service because basically the veterans at that tell us over and over again, once they get in the system, they are very satisfied with the service. So that is not a misnomer.

Ms. McCaughey, I have a question for you because we are looking at the different systems and advantage care as opposed to VA system and TRICARE. Advantage care costs us more money.

Ms. MCCAUGHEY. I think you are referring to Medicare Advantage?

Ms. BROWN. Yes, exactly.

Ms. MCCAUGHEY. Okay.

Ms. BROWN. But in your testimony, it seems as if you are recommending that as——

Ms. MCCAUGHEY. No, I was pointing out that a large number of vets have enrolled in Medicare Advantage and yet they are going to the VA hospital for their care. So, in fact, we are paying for it twice. I was pointing out that literally ten percent of the VA health care budget is going to vets who have another kind of coverage. It is just a tragic inefficiency when you look at we are discussing money and where to get enough money to care for our vets and then you find something like that which was documented recently in the New England Journal of Medicine—I am happy to show you the article—and we think why aren't people figuring out that such a large number of vets are paying for care—we are paying for their care twice? We are paying to the insurance companies that run Medicare Advantage plans and we are paying again to the VA system. Let's, at least, sort it out and get it straight; that is what I was suggesting.

Ms. BROWN. But I am just trying to be clear that the VA system is a system that the veterans prefer. Part of the challenges that we experience, for example, people who don't have hospitals in their area, all of this is formula-driven, and so therefore we might need to come up with some additional ways that we are going to serve veterans. In fact, until recently we have not built a VA hospital in 15 years until we appropriated for six new hospitals.

So the question is are we going to continue to build additional hospitals based on the number of veterans or are we going to come up with some partnerships that the veterans and the VA—because in the testimony that we had last week, when we sent a veteran outside of the system, we have got to make sure that it is a certain quality of care.

Ms. MCCAUGHEY. Of course.

Ms. BROWN. And if that continuity is not there, then you still going to have the exact same problem we are experiencing today.

In addition to that, I am a Mayo person, and if I have an appointment and all of the bells and whistles, and if I don't keep that appointment, there is a charge if I don't to make an appointment. We don't do that to veterans. So if they have an appointment and if they don't make that appointment, it is no penalty to them.

Ms. MCCAUGHEY. Well, in fact, there is a terrible penalty to them. It is not a monetary penalty, but it means that they are waiting longer and longer for care. And when vets don't show up for their appointments, I am not blaming the vets. If many cases, they have waited as long as six months for that appointment. The fact is that the VA hospitals and clinics should be calling the vets 24 to 48 hours or e-mailing them ahead of time to remind them of their appointments. It is unrealistic to think that a vet is going to remember their appointment——

Ms. BROWN. Absolutely. I agree with you, but still, I am saying in the other side of the world, if you don't make that appointment, there is a financial penalty that you receive.

Ms. MCCAUGHEY. Uh-huh. And what is your point, Madam?

Ms. BROWN. I made my point.

Ms. MCCAUGHEY. Thank you.

Ms. BROWN. The point is that we have additional veterans in the system because we opened the VA system up to the Vietnam veterans. Each one of them did not have to prove that they had a certain disability. So we got thousands of additional veterans into the system and the Secretary did it and I am very grateful that he did it. Now we have to figure out how to serve them, and I am saying that the VA system is one of the best systems in the United States; that is what I am saying. And I read your expertise. Your expertise is in the area of infectious diseases which is a problem, but the bill that we have before us, I am hoping and the Chairman's recommendation and his bill and the Senate Bill, I hope we can work out what is the best way to move forward with the VA system.

And thank you for your kindness and your time, Mr. Chairman.

The *Chairman.* Thank you very much, Ms. Brown.

Mr. Jolly, you are recognized for five minutes.

Mr. JOLLY. No questions, Mr. Chairman.

The *Chairman.* Thank you very much.

Mr. McNerney, you are recognized for five minutes.

Mr. MCNERNEY. First I want to thank the Chairman and the Committee for allowing me to participate in the hearing.

You know, I heard some really excellent ideas here and I have seen a real bipartisan spirit in finding real solutions, so I think it is a great morning and we have accomplished a lot.

I, first of all, have a hypothetical question for Mr. McClain and Mr. Collard. If the no-show rate were reduced to five percent, which we heard is attainable, and physicians were relieved of the non-value added requirements, which is a phrase that Mr. Collard used, would there be enough physicians to provide health care that is needed to our veterans?

Mr. MCCLAIN. I haven't actually done the math or done the analysis on this, but it certainly would help. There isn't any question about it, and that would certainly bring it closer to what the commercial expectation would be in health care delivery.

Mr. COLLARD. It is a question that is answerable. We probably don't know this. None of us at the table have the math, but it is a question that is answerable because the variables are real variables.

Ms. MCCAUGHEY. I will give you the 2012 report that was provided to Congress on just this issue, assessing the—how to assess the need for additional physicians at each location.

Mr. MCNERNEY. Please be brief.

Ms. MCCAUGHEY. I am just going to give you the report after the——

Mr. MCNERNEY. Okay, thank you.

Mr. McClain, would you talk about the current state of affairs regarding transfer of patient data between private sector and the VA and if there are barriers, how could we reduce those barriers?

Mr. MCCLAIN. We had a problem when we started out in Project HERO, we were not able to immediately input any data into the VA's medical records. In other words, we maintained a network of specialists, so a veteran would be referred out to a specialist and you would get a consult and you would get a written consult report that we ended up faxing back to the VA and apparently then it was attached in a PDF form and then attached to the CPRS, to the veteran's record.

In the CBOCs, it is a different thing. I mean we are essentially part of the VHA Health Care System and we have access to VistA and to CPRS, but it is very, very difficult—I understand the firewalls. I understand the privacy issues. I understand the IT issues that come up, but there has been a lot of work done in the commercial and civilian sector on exchange of information. I think the answer to your question is DoD and VA have been trying for over ten years to exchange information and they have been very successful.

Mr. MCNERNEY. Thank you.

Mr. Collard, in your testimony, you used a new term I haven't heard before "evidence-based leadership"; are there models for identifying evidence-based leadership? Is there some way we can move forward in helping to identify that?

Mr. COLLARD. Yeah, I think what you would find is that as you look at the models and the structures, the parallels to the other side of our evidence-based world, and that is evidence-based care. One, you begin with the diagnosis before a prescription, and so the notion of an assessment prior to just jumping into the fray becomes key.

Then the alignment towards an eventual outcome, which is really where evidence-based care goes, so alignment of goals or those desired outcomes, which also includes the proper training as a physician would receive that provides evidence-based care, the aligning of behaviors. So the agreed upon behaviors to produce the outcome and then a topic that we have not even come close to talking about today, but shown in some of the latest bills, the ability to manage the performance gap much better. Whether it is—and we will push the organized labor issue aside for a second because we have organizations that are highly organized that are very successful in managing performance. They don't let the presence of a union stand in the way. But the ability first and foremost, we recruit the highest performers in the enterprise. That the ability to look for those that seek and can benefit from development and in our industry-wide, the ability to quit hanging on to the low performers that drag the rest of the industry down. And we can argue the ends, if it is an end of one or an end of two, but if it is my grandmother in the bed, that low performer is probably causal to a lack of good care.

What that brings us, then, to, much like evidence-based care, is through research, through vetting of the data and the outcomes, the ability to standardize, the ability to then accelerate that standardization. That is kind of a quick model of evidence-based leadership.

Mr. MCNERNEY. Thank you.

And, again, I thank the Committee for allowing me to participate.

The *Chairman.* Thank you, and welcome back. It is great to have you with us.

Members we now have a series of votes that have been called. What we are going to do is thank our panelists who are here with us today. We look forward to communicating with you off-mic as well. You have helped bring some information to us today that I think is very worthy of consideration and we cannot fail. As we have already talked about, we do have an opportunity that does only come about once in a lifetime to be able to fix this for the veterans.

Dr. Jesse, I apologize. I would rather us go vote. I don't want any members to miss a vote, and we will reconvene at the end of the last vote and we will probably be an hour.

[Recess.]

The *Chairman.* Joining us on our second panel from the Department of Veterans Affairs is Dr. Robert Jesse, Acting Under Secretary for Health. Dr. Jesse, thanks for being with us today. Thank you also for indulging the committee members while they went to vote. And with that, you are now recognized for your opening statement for five minutes.

STATEMENT OF DR. ROBERT L. JESSE, M.D., Ph.D.

Dr. JESSE. Thank you, sir. Thank the Ranking Member Michaud and the committee. I am actually really pleased to be here. And I sincerely mean that. I thought this morning's session was fantastic. There were a lot of incredible topics that were discussed.

As you know, I have a prepared statement. I am not going to read that because I want to respond to some things from this morning. But I do want to say a couple of things up front.

The *Chairman.* And your statement will be entered into the record.

Dr. JESSE. Yes, thank you. I would be remiss if I did not start by just saying we know that we have left veterans down, but we are going to make it right. There has been a breach of trust. Many patients have been waiting too long. We need to fix that. It is unacceptable. It is unacceptable to the veterans. It is unacceptable to the American people. And it is unacceptable to you. And we need to apologize for that and we will do so. We apologize to the veterans; to the VSOs; to Congress; to the American people. You all deserve better from us and we will do that. We own this. We are going to fix it.

We will do it with diligence. We will do it with haste. We will do it with integrity. And we will do it with unparalleled transparency. And I think from several of the hearings we have had in moving forward you will begin to hear certainly how VA is moving now to provide care for patients. We believe we have identified patients who are still waiting through the process you have. We are bringing them in. If we cannot get them in to get care in 30 days if they choose we will find care for them in the outside. That is our job one. That is the most important thing that we have to do. It is our most important focus.

You have mentioned several, you mentioned that there are ongoing investigations. People will be held accountable. I want to say

one thing that I am very concerned. I care deeply about the other employees in this organization that have been doing it right. There are 270,000 employees in VHA and the majority of them come to work every day driven on a mission, a sacred mission they have to do the right thing for veterans. They do work for veterans and close to 40 percent of themselves are veterans. And I think we have to acknowledge them, and their health, and their well-being are very important.

We need to know how this organization failed and I think and I hope that is the topic for the discussion today. You know, how did the VA bureaucracy, you are not going to like that word, how did the VA organization structure become what it is today? And how is that impacted on what is happening in the VA?

And we are going to need help. We are not going to fix this by being a little bit better ourselves. We are going to fix it by the kind of very robust discussions that were held here this morning and through, you know, learning from the Mayo Clinics, learning from the Kaisers, and others. And we frankly are having some of those discussions going on now.

So this really is a time to reset. This is I think a crucial moving forward moment. And if we do not take the opportunity to do that, we have been remiss. There was a lot of talk this morning about patient centered care. Our plan moving forward, which we have been inculcating across the organization for the past year, is that we are going to have patient proactive, proactive, personalized, not just patient centered care, patient driven care. I think that is a very important distinction. We need to move from being the model of finding it faster and fixing it better to one that treats the front end of disease prevention and wellness.

Standardization is incredibly important. I agree absolutely with Mr. Collard, that, you know, people say well if you standardize you cannot innovate. In fact you cannot innovate if you do not standardize. And this is as we have rebuilt our sterile processing around an ISO 9001 structure that provides a level of standardization that allows disciplined improvement.

Centralization is important. It is best when it is standardized. It is not an equivalent to standardization. If you standardize business practices, that is great. You get efficiencies of scale and you get an operational consistency that is important. But there are other ways that are important. And for example, our CMOPs, our mail order pharmacies. You know, the seven mail order pharmacies have for the third year I think now in a row won the J.D. Power Award for pharmacies. They mail out 120 million prescriptions a year. Why is that important? What it did is it freed up the pharmacists, it got them from out behind the counter to out in the clinics and sitting with patients, doing medicine reconciliations, improving adherence to their regimens which in the end is really what improves outcomes.

And then there was a lot of talk about competition. And competition this days in healthcare is actually choice. And if we are not the healthcare agency, if we are not the healthcare delivery system that veterans choose, then we will have lost. And coordination of care is important. And in talking about a big idea, one of the things we have learned is that to relentlessly drive an organization on

performance measures that are process measures will not get us where we need to be. We want to relentlessly drive this organization on value. Value is quality over cost. Quality is in the eye of the beholder, so there are multiple dimensions to it. And cost is not always in dollars. It is the opportunity cost, it is the emotional cost of getting care. But we need to make that equation right for the veteran, for you all as our oversight board, and for the American public. Because if we are not a value to all of you, again, we will not have met our mission.

So thank you, sir. I again thank you for the first panel. I thought it was excellent. And I am prepared to have a further discussion.

PREPARED STATEMENT OF ROBERT L. JESSE, M.D., Ph.D.

Good morning, Chairman Miller, Ranking Member Michaud, and Members of the Committee. Thank you for the opportunity to discuss the current organizational structures of the Veterans Health Administration (VHA). At the outset, let me address the significant issues that have been the focus of this Committee, the VA, and the American public the last many weeks. That is the issue of wait times. No Veteran should ever have to wait an unreasonable time to receive the care they have earned through their service and sacrifice. America's Veterans expect and deserve the highest quality, timely health care.

As former Secretary Shinseki and Acting Secretary Gibson have stated, we now know that within some of our Veterans Health Administration facilities, VA has a systemic, totally unacceptable lack of integrity. That breach of trust—which involved the tracking of patient wait times for appointments—is irresponsible, indefensible, and unacceptable to the Department. Let me apologize to our Veterans, their families and loved ones, Members of Congress, Veterans Service Organizations, and to the American people. You all deserve better from us.

Earlier this week, Acting Secretary Gibson announced a number of immediate actions to address the issues identified in our audit. Specifically, and of relevance to this hearing, on June 9, 2014, Acting Secretary of Veterans Affairs Sloan Gibson ordered an immediate hiring freeze at VHA Central Office in Washington, D.C. and all 21 Veterans Integrated Service Network (VISN) headquarters, except for critical positions, which will be approved by the Acting Secretary on an individual basis. This action will begin to remove bureaucratic obstacles and establish responsive, forward leaning leadership to accomplish VHA's mission of providing exceptional health care that improves Veterans' health and well-being.

External independent organizations have stated very clearly that VHA delivers high quality care across the nation to 6.3 million Veterans and other beneficiaries living in urban, rural, and highly rural areas. Today, our care delivery includes: 150 medical centers, 820 community-based outpatient clinics, 300 Vet Centers, 135 community living centers, 104 domiciliary rehabilitation treatment programs, and 70 mobile Vet Centers.

We collaborate with Federal partners, such as the Department of Health and Human Services to establish pilot projects with community-based providers, the Department of Defense (DoD) to improve

access to care for Servicemembers and Veterans through sharing agreements, and the Department of Housing and Urban Development (HUD) on the HUD–VA Supportive Housing (HUD–VASH) program. Other responsibilities include the training and development of a workforce of over 300,000, coordination of a nation-wide volunteer program, and a range of special program offices, to include Rural Health, Telehealth, Informatics, Mental Health, and Procurement and Logistics. Directing and supporting this organization – the largest integrated healthcare system in the Nation, requires an Administration-level headquarters, an intermediate level of oversight (Veterans Integrated Service Networks), and a hospital-based network of front-line decision makers.

VHA is committed to consistent and efficient use of staffing resources across its health care system. Since the 1990s, VHA has used VISNs to direct and oversee health care delivery. Each VISN oversees a grouping of hospitals and other specialty facilities, such as community living centers, domiciliaries, community-based outpatient clinics, and Vet Centers. VISNs also share innovations at regional level and collaborate with other networks to elevate validated strong practices to the national level; integrate health care services within markets; monitor and assess the delivery of health care to Veterans; and reduce or eliminate duplicative functions in clinical, administrative and operational processes.

In 2013, VHA evaluated each VISN's functions and staffing levels, and established a smaller and more uniform core size and set of functions. We believe the organizational structure of VISN offices and local health care systems supports our mission with a level of consistency that assures the efficient and safe delivery of health care to Veterans. However, in light of recent events, we also intend to take a fresh look at our Central Office configuration and endstrength, as well as VISN functions and staffing levels.

Additionally, in order to help provide timely access to quality healthcare, the Department has announced other initiatives VA will apply at the facility level, including the hiring of additional clinical and patient support staff as well as other temporary staff. VA's priority is to ensure all Veterans receive timely access to high quality care, and we are prepared to make those organizational changes that will achieve this end.

Mr. Chairman, the health and well-being of the men and women who have bravely and selflessly served this Nation remains VA's highest priority. VA recognizes the critical role that VHA Central Office and VISNs have in providing quality, integration and value in the delivery of health care to Veterans. The recent VISN staffing review and standardization strengthened the role that VISNs have in delivering high-quality, patient-centered care to Veterans through our medical centers and their staff. As we have recently learned, continued review of this and other areas of VHA organizational structure must remain a priority. Mr. Chairman, this concludes my testimony. I am prepared to answer questions you or the other Members of the Committee may have.

The *Chairman.* Thank you very much for being here, Dr. Jesse. My staff asked the office, and I know this is not under your purview, but what I asked for is, I asked the Office of Congressional and Legislative Affairs to provide an organizational chart for VA's

Office of Mental Health Services to include accompanied names and titles on the 18th of April. On May 7th my staff was informed that this deliverable request would require either a letter from me, as the Chairman, or to go through, now get this. Members, a Freedom of Information Act Request.

I sent a letter requesting the organizational chart in writing that same day. However, I still do not have it. So either a chart does not exist, or VA does not want to share it with the committee. What do you think about that?

Dr. JESSE. Well, first of all I apologize. There is no reason why you or anyone else should not have an organizational chart. I am actually surprised they are not available on the web. But I apologize you are being put through that amount of effort to get it and I will get it to you.

The *Chairman.* By close of business tomorrow would be appreciated. Can I have your personal assurances it will happen?

Dr. JESSE. I will certainly try, sir.

The *Chairman.* Thank you very much. I heard you put a try in there, but there is no reason that we cannot have it by tomorrow.

Dr. JESSE. Well——

The *Chairman.* And if not I am, yes, or if it does not exist, you are correct. During a recent visit to the Columbus, Mississippi CBOC I was told that many veterans choose to utilize the Tuscaloosa, Alabama VA Medical Center rather than the Jackson VA Medical Center because it is a closer proximity.

Dr. JESSE. Mm-hmm.

The *Chairman.* It was mentioned that there is a memorandum of understanding in place to allow this choice for veterans. So I guess my question is in a supposedly integrated system, why is there a need for this type of bureaucracy in order to cross a VISN line?

Dr. JESSE. I do not know the answer to that. Particularly if there is a memorandum of understanding that the people can go back and forth. We have since I think the days of Dr. Kaiser have said it is one VA. The veteran should be able to choose which VA he goes to. So I do not have the explanation for that.

The *Chairman.* If you could also for the record——

Dr. JESSE. Yes.

The *Chairman.* —get that. The other thing is, why are veterans who cross VISN lines categorized as new rather than an established patient?

Dr. JESSE. Yes, that I know they are not supposed to. And I know this because I looked into it a little while back. I had been up at a clinic up in South Dakota and I was walking past a waiting room and there were gentlemen sitting there and they said, a guy says, "Guys in suits, they must be from Washington. Get in here." So I went and talked to them and their comment was that they loved the care they were getting in South Dakota. But no one stayed in South Dakota. You know, retired people tended to go to warmer places in the winter. And their only complaint was that if they went somewhere else that they were not recognized even though they were going to the same place over and over again. So I came back and looked into that. There is a process that people

are supposed to follow to do that. And you know, apparently we do not have that message out as clearly as it needs to be. It should not happen. Once you are in the VA, you should be in the VA. You can be found.

But I will also say that there is an initiative going on now to actually not just do that across VHA but across all of VA. So that if, whether you change an address in the benefits side that gets pulled over into a master index so that the whole entire agency sees each individual as one person and not having multiple different iterations across. And we need to do that in order to make this seamless.

The *Chairman.* When VHA issues a policy letter or a directive, how does that instruction flow from the central office to the field?

Dr. JESSE. So the technical process is that as the directives get signed off by the Under Secretary then the distribution route goes through the networks. So it goes through network operations down to the network directors, and then from there it tiers down to the facilities and into the field. And at the same time the bottom, the last line of virtually every directive, well at least the ones, the clinical ones that I have been involved with, will have who your point of contact is if there are questions. So there are ways to move clarity and technical expertise back to the folks who are trying to implement that directive.

The *Chairman.* And my final question, and I am running out of time, but the committee has been told repeatedly that the VA central office policy is often transmitted outside of any authority chain and often viewed by many VA medical centers as voluntary. Is that true?

Dr. JESSE. I certainly hope not. No, a directive is a directive. And they are very explicit statements about what is required. If there are options and opt outs, they will be placed in that directives. You know, I think the key principle needs to be that directives are not ambiguous, that their intent is clearly defined, that the metrics by which they are going to be measured are clearly articulated, and that there is a solid and defined methodology for ensuring that they are in fact being met, and the intent of the directive has been met.

The *Chairman.* Thank you. Mr. Michaud, you are recognized.

Mr. MICHAUD. Thank you very much, Mr. Chairman. And thank you very much, Dr. Jesse, for being here. My question is, you heard earlier Dr. McCaughey and, for the record, I mean, Dr. McCaughey is not a medical doctor so——

Dr. JESSE. Yes.

Mr. MICHAUD. —raised a number of concerns with the choice card provision in the Sanders-McCain bill. Do you see any problems with VA's ability to provide veterans with eligibility verification such as choice cards to see non-VA doctors?

Dr. JESSE. You know, I do not know explicitly. But we have been doing this, there are several different methodologies for non-purchase non-VA care, one of which is fee although that term tends to be used an encompassing. And when we give somebody a fee card it is equivalent to that. It is the authorization for you to go out and get your care. And there are some limits around that. It is not a preauthorization but there are bounds about what care can

be provided and if it has to exceed that then they get authorization. I believe that is the way it works. So it should not be an inhibiting factor and I think you heard from Philip Matkovsky the other night that, you know, he really is putting rigor and discipline around our business processes. And I think if that were the type of case it would not be a phone call to a random number somewhere. We would have one of the business, the health resource centers run by the business office would be managing that I would presume. Until, you know, until we have a law and we have the regulations around it it is a little bit difficult to speculate. But we have the capability to do that.

Mr. MICHAUD. Okay. So when the VA does it today do you have any problems with verification?

Dr. JESSE. Well I am not going to say it is perfect. But I think, you know, for most cases it is effective. You know, we have been looking at, always looking at better ways to do it, Project HERO and Project ARCH. We are set up for that as pilots, to see if there is a better way to get that distributed care out there.

Mr. MICHAUD. And Project ARCH is in Maine.

Dr. JESSE. Yes, I know.

Mr. MICHAUD. It is, veterans and everyone, they love the way that has been working, so.

Dr. JESSE. Yes.

Mr. MICHAUD. The VISN structure has been under scrutiny for a few years now and I understand that VHA has reduced the number of headquarters staff through a realignment effort. Is that process finished?

Dr. JESSE. Well I would rather think of it as a work in progress. So there was a task force, a group that looked at this. And clearly there was wide variation in the size of each of the VISNs that could not be explained on either the size of the VISNs themselves, meaning their total number of unique veterans, or their purpose because their purpose is inherently the same. So what this group did was they came back and clearly defined the core roles that needed to be in each VISN office. And on some limited amount of flexibility around that, which was fundamentally driven around the size of the VISN. And so we went from a variation of I think at the low end just under 40 people in a VISN office to a high end of 160, to that they are all male between I think about 55 and 65. Clearly defined roles, that this is what you must have in there. A little bit of flexibility. But there is not an ability to continue to flex up that staffing without coming in for further review. And I say it is a work in progress because it has been pushed out this year. We will see how it works. I am constantly looking at it, and if it needs to be smaller we will make it smaller. If it needs to be bigger, we will make it bigger, or if we need to rethink the process entirely. But that is what we did. So we tried to standardize at the VISN level.

Mr. MICHAUD. Thank you. And just to follow up on the chairman's comments about getting a directive from central office and having the VISNs carry through with that directive. And these are, you know, I have heard comments that the folks at the VISN level are more concerned about the VISN director's interests in how things are run versus the Secretary's because the Secretary comes and goes. And I have also heard it on the VBA side as well when

the American Legion came out to do their System Worth Saving brought note to the fact to VA employees that is not what central office said you should be doing for the benefits. And the response, and this is the Baltimore, Maryland VBA, was, well, there is the VA way of doing things, and then there is the Baltimore way of doing things. And we are doing it the Baltimore way. So I think there really is a problem in some of the areas and I would encourage you to make sure that when the directive does come that it is followed through.

And the other note I want to say, since my time is running out, when you look at Department of Defense they have the world divided in seven different regions. And I question whether or not we need 21 VISNs throughout the country. So I will end on that note and yield back, Mr. Chairman.

The *Chairman.* Thank you very much. Dr. Benishek, you are recognized for five minutes.

Mr. BENISHEK. Thank you, Mr. Chairman. Dr. Jesse, good afternoon. I am looking at this organizational chart of the VA. I guess it is the Veterans Health Administration. And I am wondering, if a physician within the VA wants to lodge a complaint or make a suggestion, where on this chart does that occur? I mean, I do not see a place really that has physicians.

Dr. JESSE. So there are two places, actually. On that chart there is Dr. Madhulika Agarwal who is the Deputy Under Secretary for Policy and Programs. And in that is Patient Care Services. And rolled up under Patient Care Services are much of the physician based and other clinical services. So——

Mr. BENISHEK. Well I guess I, the reason I am bringing this up is, you know, I worked at the VA, and I talk to many VA physicians, and they complain that they have very little recourse when they have suggestions for changes or complaints within the system. I notice here on the chart here that the Office of Nursing is right here on the, reports directly to the Principal Deputy Under Secretary.

Dr. JESSE. Yes, sir.

Mr. BENISHEK. Well why is there not a similar place for doctors?

Dr. JESSE. Well so the physicians work through programs. So the Office of Surgery——

Mr. BENISHEK. Well what I am trying to get to——

Dr. JESSE. Okay.

Mr. BENISHEK. —is that it seems like the nurses have more input to leadership than the doctors do. And you know, the doctors often have suggestions that may improve the quality of patient care. And I do not, the physicians I talk to, I just talked to a group of VA physicians yesterday and they are frankly telling me that they get reprimanded and they have this retribution if they try to change the system. And have you ever heard about that?

Dr. JESSE. So——

Mr. BENISHEK. I mean, I have had VA physicians tell me that they were not allowed to talk to me by their superiors. They were told not to speak to me.

Dr. JESSE. So let me if I may——

Mr. BENISHEK. Is it the policy of the VA to not allow physicians to speak to members of Congress?

Dr. JESSE. Absolutely not. Absolutely not.
Mr. BENISHEK. Well I am glad to hear that.
Dr. JESSE. So, no. And remember that, if I may remind you——
Mr. BENISHEK. Well I ——
Dr. JESSE. —that I come to this as a clinician who was going to——
Mr. BENISHEK. —why would it be that physicians have been told not to speak to me?
Dr. JESSE. I have no idea, sir. It is not right. Physicians have the right to speak to anybody.
Mr. BENISHEK. Well that is what I would think.
Dr. JESSE. And there is a mechanism through, surgeons have the Office of Surgery. Dr. Gunnar has been a stellar leader in that, that they can work directly up through.
Mr. BENISHEK. Well what I am telling you is that this stuff occurs.
Dr. JESSE. Emergency medicine has the Emergency Medicine——
Mr. BENISHEK. This stuff occurs. This stuff occurs, okay? This is occurring now, today, yesterday.
Dr. JESSE. Well I——
Mr. BENISHEK. This pattern of veteran, or physicians within the VA being told not to speak to Congress, being told not to rock the boat because if you try to make it more productive it is going to make somebody else look bad. I mean, these are direct quotes from physicians that work within your system.
Dr. JESSE. So I also work with those physicians. And you know, much of the improvement that physicians want to execute occurs at the local level and we identify best practices at those levels at those levels and we use or, leverage our network capability to distribute them. There is no reason that physicians should not and cannot communicate freely. How can we have improvement if people do not feel that they can exercise——
Mr. BENISHEK. Well that is the situation as it is today.
Dr. JESSE. So I would, I would like——
Mr. BENISHEK. I mean, I was at a VA physician meeting where there were perhaps 50 VA physicians. And the common theme of the discussion was that they were afraid to talk to me and what can be done, I am afraid to tell you what is going on at the VA, doctor. Because everyone has told us that we will be punished and that they were put through like onerous peer review situations that were obviously punitive. And so that they were afraid they would not be able to practice outside the VA.
Dr. JESSE. Well——
Mr. BENISHEK. I am just telling you what is occurring.
Dr. JESSE. —that is inexcusable. And I will, I will personally——
Mr. BENISHEK. So can you pledge to me that if I speak to a VA physician and he complains to me that he was reprimanded, you will help me make sure that this whistleblower guy does not get punished?
Dr. JESSE. Well we do not tolerate punishment of whistleblowers. We absolutely do not——
Mr. BENISHEK. Well but I am saying it is occurring today, Dr. Jesse. So if I have a physician who talks to me, because they were asking how can, they were asking me yesterday, doctor, how can

you assure me that if I tell you what is going on that you can stop me from getting fired? And I had a little bit of trouble telling him that I could promise him that he could not get fired.

Dr. JESSE. Well I——

Mr. BENISHEK. Do you understand what I am saying? So what I am asking you is that if someone comes to me with that complaint, can you promise me they will not be fired?

Dr. JESSE. I can, sir, I will promise you that they will not get fired for complaining to you. I can do that much. I cannot speak to individual situations.

Mr. BENISHEK. All right. Thank you.

Dr. JESSE. All right? Sorry.

The *Chairman.* But also understand that if we do find that somebody has directed people not to talk to members of Congress, it is a crime.

Dr. JESSE. It is inexcusable. We do not accept that.

The *Chairman.* Okay. It is criminal.

Dr. JESSE. Yes. I think the voice of the veterans who we serve, the voice of the line of people working with veterans of every day is crucial if we are going to improve this organization. We have to be listening.

The *Chairman.* Ms. Brown, you are recognized for five minutes.

Ms. BROWN. Thank you. Sir, in Florida we serve almost 600,000 veterans. We are the third largest population of veterans in the country. And my question goes to, I personally think the VA system is an 'A' or a ten. But when I, the first year I was teaching the principal said if you are an 'A' or a ten, where is your room for improvement? So I am starting out saying I think the system is very good. What are the recommendations would you have for some improvement? Because I do not think the entire system is damaged, as I hear. And I do think there are things that we could do. I remember when Secretary Brown, Jesse Brown, when the veterans from the Northeast came to Florida, we serviced them, and we did not get reimbursement. The reimbursement stayed in the North. So I mean, I know a lot about the institution, probably more than anybody on the committee.

Dr. JESSE. So how can we improve? Well the first thing we can do, as you heard earlier today, there are many VA facilities that are top achievers——

Ms. BROWN. Mm-hmm.

Dr. JESSE. —incredible performance. But not everybody is there. And the first thing we need to prove is to get everybody up to that same level. The second is, we say we are a quality organization. But I constantly remind our staff that there are multiple domains to quality. One of them is access and one of them is timeliness. So if you cannot have access you cannot even have quality. So fixing this access problem and doing it immediately is key. Third is equity. You know, if there are inequities in the delivery system we have got to identify them, we have got to figure them out, and we have got to make them go away quickly. So as we improve the standards of all hospitals, raising all boats up to what we know we can achieve, but also ensuring that access, quality, equity are uniform principles of how we do that work.

Ms. BROWN. We had a hearing, the Florida delegation, on VA this morning and one of the recommendations, at one time the VA could just I guess hire a doctor and now they have to go through a different system?

Dr. JESSE. I am not sure what you mean. We have a process for credentialing and privileging physicians.

Ms. BROWN. Mm-hmm.

Dr. JESSE. It is not unique to the VA. Every hospital in this country will do the same thing.

Ms. BROWN. Mm-hmm.

Dr. JESSE. Our process is actually, the credentialing process is pretty good. But one of the things we are doing is we are working with DOD because they have got one too, but it is different from ours, and trying to establish a federal wide credentialing process. So if somebody came from DOD over to the VA, they would not have to do it again. And even more important in the conversations around telehealth where you have now got people practicing across state lines——

Ms. BROWN. Mm-hmm.

Dr. JESSE. —you can have a uniform set of credentialing, that takes time. The one thing that is unique to VA is that physicians especially, but I think almost all employees have to go through security and background checks——

Ms. BROWN. Mm-hmm.

Dr. JESSE. —and that takes some time. What we are trying to do, and in fact we learned a lot of lessons if you remember last year when we had the hiring initiative to plus up the mental health workforce, we learned a lot about the speed of hiring. And the challenge but simple solution is do not wait for Step A to fix, before you start Step B, before the start Step C. Parallel process, you can cut down that time. If we do not do that, we lose people while they are waiting to get their job.

Ms. BROWN. And nursing is another example that it takes so long for us to process a nurse.

Dr. JESSE. Yes——

Ms. BROWN. And how do we advertise? Do we advertise just in the VA system? Or I mean, how do we do it?

Dr. JESSE. Well so there is a requirement, I believe, that all federal jobs have to be posted in, you know, at a federal website so everybody can see them. But I do know, you know, for instance when I am reading the Richmond paper there is, you know, on Sunday morning there are always ads for the VA looking for nurses there. So, you know, everything goes into a, you know, a website. But in fact you use local resources. We also have executive and physician recruiters as part of Workforce Services that go out and reach out and try and find these people. And we leverage them in the metal health initiatives, they were very effective.

Ms. BROWN. One last thing. We have had lots of discussions of how we get additional VA doctors into the system and what can we do as far as, I guess, the medical, what is it? The medical so that they can get I guess forgiveness on their loans——

Dr. JESSE. Yes.

Ms. BROWN. —when they work for the VA. Or whether, in Florida, for example, a lot of our interns go out of the state because

we do not have the—what is the word? So they go out of the state. Residency, yes. And so we do not have those slots. What can we do?

Dr. JESSE. And so there are two things that you are asking about. One is can, for people who have large medical school debt, and the average is pushing upwards to a couple of hundred thousand now——

Ms. BROWN. Mm-hmm.

Dr. JESSE. —if you do not have help somewhere along the line is can we do debt forgiveness. We do have some limited authority. It is insufficient.

Ms. BROWN. It is insufficient?

Dr. JESSE. We have been talking to, and particularly where we want to place physicians in underserved areas, which is the real challenge. It is less of a challenge, people want to stay around where they did their residencies, so in urban areas with bit medical schools it is much less hard. So we have been working with HERSA, who has the program where they pay scholarships and loan reimbursements to people who work in designated underserved areas, many rural but not all. And it does not make sense for us to build another organization within VA to replicate that process if we are going to go that route, which I, you know, I think we should if we can. There is, you know, we have got to make sure. But to tag onto them. They have already got the infrastructure in place. They can move out immediately.

And then the, you know, the other piece is increasing residency slots. VA is highly supportive of the residency training programs in the U.S. I think you heard earlier about 70 percent of physicians get some of their training in the VA system. We have expanded that in certain areas. There is still not sufficient, well for mental health it is not that there is not sufficient residencies, in fact some of them have closed because there is not sufficient people going into them. So how does not incentivize that mental health community, that more physicians would want to go in there. And that is not a question that VA can answer, but we can support the slots when we need to.

I think there is, the other piece of this, and it was also mentioned earlier, is how does one leverage the use of both nurse practitioners and physicians assistants, and the like. And it is our intent within the organization that people practice to the top of their license. And so I think supporting PA schools, supporting nurse practitioner programs, we have got the VA nursing academies which are very useful for bringing people in nursing into the VA systems. And we are also now training people in interprofessional training so that doctors and nurses train side by side and learn to work as teams. And people who go through that find that is a very satisfying career move. But we have got to start that early in the training programs and not wait till they graduate and then try to retrain them to a different way of practice.

Ms. BROWN. Thank you so much, and my time is up. And you have been very gracious, Mr. Chairman.

The *Chairman.* Yes, ma'am. Thank you. Mr. Huelskamp, you are recognized for five minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman. Dr. Jesse, earlier you made some comments about responding to congressional requests and stuff. Could you restate what you said about that? Something about criminality or criminal if you did not——

Dr. JESSE. Oh, I do not think I used the word criminal. But I do not think that it is excusable that a physician thinks he cannot talk to his member of Congress.

Mr. HUELSKAMP. Okay.

Dr. JESSE. That is, and nor do I think anybody in VA should be telling——

The *Chairman.* Would the gentleman yield?

Mr. HUELSKAMP. Yes.

The *Chairman.* Very quickly, if you can hold the clock? What I am referring to is them being directed, not that the physician or whoever the clerk may be. Obviously it is in the investigation that a committee is trying to do as it relates to its oversight responsibility in Congress. So I was not implying that the physician was. But it is our understanding at the committee that there have been people who have been instructed not to talk——

Dr. JESSE. Yes. So, well, do you want to, I can maybe put some context around that? Because——

The *Chairman.* If you just hold the clock, and go ahead.

Dr. JESSE. Okay. So right now, yesterday, today, this past week, as you know, VA has been putting out a lot of the wait time data as part of being very transparent about this. There has been concern that at the facility level they may not be looking at exactly the same data that we were releasing. We wanted to be very careful that we did not have facility or network directors appear to be misleading their congressionals by saying well this is where we are, and then having this national data release say something different. So there was a caution put out to wait until we had distributed the data to them that was going to be released. And I will say it was an ill-worded document that it was followed immediately by a statement of clarity that said it was not intended that they could not talk to congressionals, to just hold off until they had the data that they could talk to them about and ensure they were getting the right data. You know, we get terribly compromised if we do not, if we have got one person saying one thing and another saying another. And we want to make sure as we move forward especially, and understanding what we put out this week is only the first, the first drill at this, we will be repeating that on two-week intervals. So anyway——

The *Chairman.* Thank you very much for that clarity. It does add some light onto the issue.

Dr. JESSE. Yes.

The *Chairman.* But I will also tell you this. We were told by Dr. Lynch two weeks ago, because every member of this committee has been asking for the data from their facilities. And we were told that we would receive it once the report was final. The report is final. I got a call today that my local media got it before I did. I just do not understand why people in the VA will not follow through with their commitment. Now you do not need to respond to that. But that is a statement. I yield back to Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate that. I did want to read from an email that was handed to me by I guess an Acting Director, and for members of the committee I did not know this. If the Director and the Assistant Director are on vacation, or on a management conference at least in the Wichita VA facility, the Acting Director is the Chief Nurse. But handed me an email that said please immediately stand down on any further communications with stakeholders, delegation members, and others regarding the access audit, wait lists, and accelerating care initiatives. And I did not take that very well.

Dr. JESSE. No, I, and——

Mr. HUELSKAMP. Can you explain——

Dr. JESSE. Well so actually I probably——

Mr. HUELSKAMP. —so this was approved at the highest levels? Who approved this stand down message?

Dr. JESSE. No, no. I saw that memo, and I personally saw that memo probably five minutes after it went out and I said this is not acceptable. If that cannot be pulled back then you need to put a clarification memo immediately to explain the intent is not to have you not talk to your congressionals, the intent is to wait until you have the data from us to share with them. Because we, frankly——

Mr. HUELSKAMP. And I appreciate that explanation. The follow up email was five hours later, actually five and a half hours later, after I had sat there trying to get answers to questions. And let me describe, and you might have missed this the other night. Because I requested this email. The facility eventually provided it to me. Your office did not. The VA administration did not. I requested that at our last hearing and had to get that from the facility, so I appreciated that. But here is what occurred in one facility, and again there are numerous examples across the country and so I am trying to draw attention to one facility in Kansas that is not in my district, I do not have a hospital in my district, so we are always leaving the district for that. But here is what occurred.

May 30th, the facility announced, or actually had a U.S. Senator visit the facility about noon and was told by, I think, if the Director was there that day, I do not know. He seems to be taking a lot of time off. But I think it was the Acting Director for the day said we have no problem here. Three hours later a fax went out that said we had discovered nine veterans on a secret waiting list, maybe unauthorized. And that was sent out to the delegation and the public at 3:00 Friday afternoon. I began calling once I landed in an airport, calling, sent emails, had no response for five days, no answers. Hey, we will get together with you but would not answer questions. Then there was a leak to the media of 385, rumored. And so I jumped in a vehicle, drove to the facility, and was handed this email, and said go away. Go away.

And I did not. We stood there, and I finally got the Director on the phone who was in Denver at a management conference. But since then, this is what is concerning as well, since then they have discovered another 636. So there is over 1,000 veterans on the waiting list. And doctor, here is what they told me. We did not know we even had a near list. We did not know that was in the system. The system that has apparently been around for twenty-some years, this facility did not even know. And I am not asking

you to explain this. But I am asking, maybe this is why we need some more investigation, more people should show up and ask those questions. Because either they are misleading or worse, or frankly incompetent if you did not know you had these veterans sitting on a list. And as I understand the numbers that were released in the audit do not include other unauthorized lists. That is still yet to be known, is that correct?

Dr. JESSE. Well if we do not know where unauthorized lists are, we cannot include them. The——

Mr. HUELSKAMP. Tell me how you are going to find them.

Dr. JESSE. It does include——

Mr. HUELSKAMP. How are you going to find them then?

Dr. JESSE. Well——

Mr. HUELSKAMP. I understand that you do not know.

Dr. JESSE. Right. So——

Mr. HUELSKAMP. But you did not make any reference to other unauthorized lists that were found in Phoenix, the types found in Phoenix. You did not make any reference to those at all.

Dr. JESSE. So the near list everybody should know about. And I do not say this as an apology, but there is a software defect that gives a different number if it is pulled locally than if it is pulled nationally. So all of the near data is being pulled nationally and the sites have been directed to go to the VSSE, the national center, to pull their data down. But——

Mr. HUELSKAMP. How long did you know about this glitch in the data?

Dr. JESSE. As we were trying to pull this data together. That is, because this is the problem. We had facilities saying we do not have——

Mr. HUELSKAMP. Okay. We have had two weeks of hearings and this is the first time you have said the near list is a data glitch.

Dr. JESSE. The near list is part of the process of scheduling.

Mr. HUELSKAMP. It is not in the Dole VA facility. That is not accurate. Or else they are lying to me.

Dr. JESSE. Well I——

Mr. HUELSKAMP. And my question is, it is not about just the one center, or one hospital. This is systemic, nationwide, where basically what you are telling me is the near list is everywhere, that is what they told us two weeks ago. Then I go to a facility and what they say is we did not even know there was such a thing as the near list.

Dr. JESSE. Well I cannot speak for a single——

Mr. HUELSKAMP. Well how about finding an answer to that?

Dr. JESSE. I will ask them.

Mr. HUELSKAMP. Can we do that?

Dr. JESSE. Sure, I will ask them.

Mr. HUELSKAMP. And in the future when I request documents, I would appreciate you provide them. Especially ones that had gagged employees. I want to give them credit. They went ahead and answered despite Janet Murphy's direct instructions to not talk to me.

Dr. JESSE. Well as I said, that was not the appropriate statement. And I hope we did get that corrected.

Mr. HUELSKAMP. Who did approve that statement?

Dr. JESSE. Nobody, it was Jan Murphy, well it was put out. Not every email gets approved by——

Mr. HUELSKAMP. Well a gag order email, I just want to know who approved it. Janet Murphy?

Dr. JESSE. Jan Murphy sent it out.

Mr. HUELSKAMP. But who approved it?

Dr. JESSE. Well I do not know. I saw it after it was out and I am the one——

Mr. HUELSKAMP. Can you tell me who approved that? Was it at a higher level?

Dr. JESSE. I do not, no, I cannot.

Mr. HUELSKAMP. You cannot find that out?

Dr. JESSE. Oh, I could find it out——

Mr. HUELSKAMP. Please find out. Thank you.

Dr. JESSE. But I will say we tried to correct that because it was not intended to be a gag order. I thought it was a poor choice of wording. No question, it sounds like that. It was not the intent. The intent was to ensure you saw the right data and you did not get in the conflict of where they were saying one data, and then you would see another piece. We want to make sure we are speaking on the same page.

The *Chairman.* Thank you, Dr. Jesse. Ms. Brown? Ms. Brownley?

Dr. JESSE. Brownley?

The *Chairman.* All right. Oh, that is right, I let you go way over. Ms. Brownley, five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you, Dr. Jesse. I wanted to agree with our opening comments regarding our veterans who work within the VA. And I do believe that most of those veterans are working hard every single day and are doing a good job. And I believe that these men and women who served in uniform were dedicated and I believe these men and women who are no longer in uniform are equally as dedicated.

I certainly do not want the men and women working within the VA to be discouraged. But they do need to understand that they have been working in a system that has lost its way and a structure that has lost its way and as a consequence was, particularly in this wait list issue, doomed to failure. And so I do not want them to miss, I do not want them to misunderstand in these discussions that this is not a criticism of them individually but it is a criticism of the system in which they were working.

Dr. JESSE. Thank you for that.

Ms. BROWNLEY. And to that end I was also curious to know from you what the VA is currently doing. We are all trying to get our arms around the problem and to fully define the problem, and how you have used the VSOs to help in that process, and how you intend to use the VSOs to come up with solutions?

Dr. JESSE. The VSOs I think are incredibly important to use moving forward. They have been incredibly important to us all along, but today, yesterday, tomorrow, moving forward, they are going to be critical. As I said, if we are going to change an organization and one that is driven on value we have to do what is important to those who we serve. And they are the reflection of that. They are, and in fact I was very poignantly told that, you know,

you did not need all your numbers to know there was a problem, we have been telling you. You needed to listen to us. I take that very much to heart.

One of the things that we have done just as a top line is, so I met yesterday with the group of the VSOs for, well we have breakfast once a month but it went much longer than we normally do because there were a lot of messages that we were, things that we were discussing. Acting Secretary Gibson has been meeting with them quite frequently as well as we are moving things forward. But the important thing is that the facility and facility directors are also meeting with their VSOs on a regular basis. And in some facilities, and I guess they are probably among the very high performing facilities, they are listening. In other facilities, they might be transmitting, but without judgment or without trying to figure out who is doing what. Our instructions forward is you must sit down with your VSOs and listen to them. You must sit and listen to them. Because that is going to be how we are going to judge the progress that we are making.

So that is, and it is very insightful on your part, and thank you very much.

Ms. BROWNLEY. So if I return to my district and talk to my, the leadership team at my CBOC in my county, that I can be assured that they have been instructed to listen to our local VSOs?

Dr. JESSE. You go back—well I hope they have, yes. And if you go back and talk to your local VSOs and they are not getting the attention that they get, we have asked the senior leadership in the VSOs to transmit the message down to their folks that work everyday in the facility serving veterans to get that back up the chain. Because that is the only feedback we will have. You know, the, obviously we can make them send minutes of their meetings and things like that, but that is not real productive. It is are people being listened to? And we can get that back by dialogue through those systems.

Ms. BROWNLEY. Thank you. And in terms of my local CBOC, we know that the demand is greater than the supply. We know that we need more space at our CBOC. That has been confirmed both by the VA and the community. And so I am just wondering, you know, how often the VA looks at long range capital plan updates? And if you have any idea when the Oxnard CBOC will be added to a long range capital plan?

Dr. JESSE. So there are two questions there. There is the SCIP, as you are aware, which is the capital asset management program. I do not know off the top of my head the prioritization of Oxnard. Although I did live in Oxnard. My dad was stationed at Point Mugu. So I grew up there. But it is, I can find out. I do not know what the status is right now.

Ms. BROWNLEY. I would appreciate it. Thank you. I yield back, Mr. Chair.

The *Chairman.* Thank you very much. Mr. Coffman, you are recognized for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman. Dr. Jesse, last year Dr. Steven Coughlin testified that VA's 2010 national health study included over 20 percent Gulf War veterans and produced important data regarding their exposures to pesticides, oil well fires, and

pyridostigmine bromide pills. Those of us who served in the Gulf War remember those. But VA has not released these data. Dr. Jesse, is VA hiding vital information about a quarter million Gulf War veterans who are waiting for care just as VA has been hiding information on veteran patient wait times? Will you provide the committee with all of the Gulf War data within 30 days?

Dr. JESSE. Well I answer the first question and say categorically not. We are not hiding data. Understanding Gulf War Illness is crucial. It is crucial. And we need that data to do that. I do not, in these data sets the way that the research is worked is to begin to publish the data and the studies that they can put together looking into that data set. This is what Dr. Coughlin was working on. VA is also actually moving towards the whole construct of open science that actually put that data, once it can be de-identified, so you do not compromise individuals' rights, out into at least in a managed public sector that other researchers can have access to it as well.

In terms of the second question, I am not sure how I can answer that. I do not know the size of the database. I can probably say with more clarity and accuracy that we can provide access to the data. But to say that can we hand it over, I do not know that. There are issues related to patient privacy and other things. But if there is, I will be glad to work with your staff to try and work through——

Mr. COFFMAN. Well certainly, you know, we are not looking for individual names here. We are looking for the conclusion of the research.

Dr. JESSE. Well——

Mr. COFFMAN. And so I think the question, and let me repeat it again just to make sure you understand it, as a Gulf War veteran I am asking you will you provide the committee with all of the Gulf War data within 30 days?

Dr. JESSE. And I answer you by saying I cannot tell you I can do that because I do not know the structure of that database. I do not know, can we provide it if it is not, if the patient privacy and protections are not taken out. And so to hand over a large research database, I do not know——

Mr. COFFMAN. So let me ask you this——

Dr. JESSE. —but I said we could get you access to the data——

Mr. COFFMAN. So if we say then that, because I want Gulf War veterans to have access to this data. Not just me. And so if we say then that minus the HIPAA protections that exist in law that you are going to turn over all the data relevant to this 2010 National Health Study concerning Gulf War veterans? That part that concerns Gulf War veterans?

Dr. JESSE. I think that is a question that is too complex for right here and now. I will be glad to personally further this conversation with you. I am not sure exactly what you want. Large databases are not something that one, it is not just the data. So what are the questions that Gulf War veterans want to answer? That is our responsibility, to engage with them and get answers to the questions that they want and need. You know that there are active researchers that have been working within the Gulf War databases. There are, you know, several incredible studies that have recently come

out in terms of trying to get to the foundations of what might be behind that. But I cannot tell you that I can hand you over a large database. I do not know the legal authorities to do that. I do not know where it would go. I do not know how it would be protected. But we can have that conversation. I just do not think we can have it here today. Mr. *Coffman.* Let us have that conversation tomorrow. Because I can tell you as a Gulf War Veteran I do not share with you your statement about the commitment of the VA for Gulf War research. It is not there. It is absolutely not there. It tries to veer off into a direction that it is kind of "all in your head." And Mr. Chairman, I would like to enter this for the record, this letter from the President of the Research Advisory Committee on Gulf War Illness, if I could put this in the record, Mr. Chairman.

The *Chairman.* Without objection.

The *Chairman.* The gentleman's time has expired.

Dr. JESSE. Mr. Chairman, if I may? I mentioned earlier, today, over at VA, there is a state of the art conference going on exploring the relationship between mitochondrial function and disease and veterans. Much of the research that has come through that committee is pointing fundamentally to a basis of that disease, much of the muscle aches, the myositis, the chronic fatigue syndrome, as being related to mitochondrial function. We have pulled national researchers, not just VA, together to begin to explore that question, and the hope to come out of this conference will be the structure for a national multi-center trial that would actually look at potential both the basis of the disease and potential treatments. There have been several of them out there that showed promise in small studies. They need to be looked at in larger studies. But they also need to be looked at with a sound basis to link the pathophysiology to the disease state to the treatments. That is going on today, sir.

The *Chairman.* Thank you very much. Ms. Titus, you are recognized for five minutes.

Ms. TITUS. Thank you, Mr. Chairman. Dr. Jesse, I have been hearing a lot of news stories, and even in this committee, where members say well the VA lied to me. Now I do not think the VA is, most people at the VA are intentionally lying. But I want to encourage you to have as much open dialogue as possible because with that transparency we can meet our mutual goal of helping veterans.

I have a good relationship with Isabel Duff at the Southern Nevada VA Health System. And we talk regularly, meet regularly. I would encourage that at all of your facilities, or areas.

Second, I would like to join Ms. Brownley in her request for information. If, when you find out about where Oxnard is on the priority list and what is happening there, would you also look at Pahrump and Laughlin? Those are two areas where you have got CBOCs that we have been waiting for some update on. If you could get that back to me, I would sure appreciate it.

Dr. JESSE. Absolutely.

Ms. TITUS. Thank you. And then the third question I would like to go back to what the ranking member was talking about, the VISNs and the restructuring or realignment of that whole system. I know you realigned the headquarters and you said it was an ongoing process to look at the realignment of the areas. Just to give

you an example of how this does not seem to make much sense. My district is Las Vegas. And so the constituents there are part of the Desert Pacific Healthcare Network. Now this ranges from rural Nevada to Central California, all the way down to the Mexican border. And the State of Nevada is split into three different VISNs. Surely we could try to bring a little more order to that regional division. Is that, are you all doing that? Is that part of what you are considering?

Dr. JESSE. Yes, and that is the next step. When the VISNs were originally set up, and brilliantly so, I might add, they were built to provide an equity both in numbers of populations, you know so they were all roughly to be the same size. Obviously the geographies were quite different. But also to follow the logical local referral patterns.

Ms. TITUS. Mm-hmm.

Dr. JESSE. All right? So if a small facility was referring to a big facility, you would not want to split them up and put then into two different VISNs. And so that is the way it was originally built. It was modified once. If you remember VISN 13 and 14 became VISN 23. But we are relooking at that. Because clearly the referral patterns have changed. Clearly the demographics have changed.

Ms. TITUS. Right.

Dr. JESSE. And it needs, that needs to be relooked at. It also does need to be relooked at in terms of the overall structure. If we do not, if we do not examine every one of our assumptions today, then we are not going to get where we need to be. So we have to question is 21 VISNs, are 21 VISNs the right number? Are the structures the right number? Are the referral patterns the right number? And that needs to be done.

Ms. TITUS. Is there a time table for doing this? Or are you——

Dr. JESSE. Well I think any time table we had is probably changed, if truth be told. Because I think, you know, particularly what you heard today, and frankly many of these ideas that were discussed in the first panel are things that we have actually been looking deeply into. But I would hate to say that we are going to put out a plan to change the VISN lines because today we really need to be relooking at the entire structure of the organization moving forward. So I apologize. That is not a solid answer. But I think the more important statement is that we will examine everything.

Ms. TITUS. Well I hope when you do you will consider potential changes in the future, demographic changes and growth especially. Because the hospital in Las Vegas, you anticipated there would be a two percent increase in demand on the system when that hospital was built, it is a 19 percent increase. I think the veteran population is going to grow generally. It is certainly going to grow in Las Vegas now that the economy is coming back. So we do not want it to be a snapshot in time. We want it to have that projected growth as part of the formula when you realign these areas.

Dr. JESSE. The, and as that hospital was put together there was great thought going into how the primary care base was going to be distributed around it and I hope that is meeting some of that need as well.

Ms. TITUS. Thank you. I yield back.

The *Chairman.* Thank you. Ms. Kuster, you are recognized for five minutes.

Ms. KUSTER. Thank you very much, Mr. Chair. And thank you, Dr. Jesse, for appearing here with us. We appreciate it. I want to focus in on some of the testimony that we heard earlier in the day and see if I could get some reaction from you, or response. We have heard a pretty incredible statistic in this committee that I believe almost 50 percent of the appointments are no-shows. And I understand you are often dealing with an older population, and transportation, and such. But it does not seem to be a very efficient or effective way to run the VHA. Has there been any consideration to either and/or telephonic scheduling, where there is a conversation about whether or not the veteran can actually make that appointment? And number two, some type of automated appointment reminder?

Dr. JESSE. Right. So actually we do much of that. I am a little bit baffled to hear as much conversation as there was today about the fact that we do not. You know, the whole principle of missed opportunities in practice management has been one of the things VA has been working very diligently on for years now. So actually when that comment was made I asked them to fact check what we are. For primary care, the no show rate is 11.4 percent.

Ms. KUSTER. Okay.

Dr. JESSE. In my clinic the no-show rate is about zero because if somebody does not show up, everybody is worried about them and we track them down. But we do use phone calls. We do, looking, and in fact the EWL, the function of the EWL is this is where patients are, and if you get an opening when you make that phone call and somebody says I cannot make the appointment, you pull people down off that list. That is the point of doing that. So we actively do practice management in that regard. So as I, you know, said, I will acknowledge the variation that occurs in the system. Some places probably do it great and others maybe not so well. But the beauty of an integrated system is that we actually can have those who do it great help bring up those who are struggling and we try and do that when we identify those.

Ms. KUSTER. So that leads to another question that has come up repeatedly today, is what is the practice about sharing best practices? Why do we have such variation across 21 different regions? And why if you are citing an 11 percent missed opportunity, why are we hearing these statistics about 50 percent? Half? More than half?

Dr. JESSE. I do not know. Because there is, first of all there will be variation around it, and it may be clinic by clinic or provider by provider. And getting that variation——

Ms. KUSTER. But if there is a system——

Dr. JESSE. But getting that variation out of the system is absolutely what is key, right?

Ms. KUSTER. And is that a metric, we have heard a lot about metrics and data——

Dr. JESSE. Yes.

Ms. KUSTER. —obviously that ran amok in the scheduling, trying to deal with these wait lists, because it led to bad behavior.

Dr. JESSE. Right.

Ms. KUSTER. Is there a way to incent good behavior by having some type of metric about patients actually getting seen? This notion of patient focused care for veterans so that we are focused on the veterans, how can we make sure that they get to see their medical care provider in a timely way?

Dr. JESSE. So we actually do have a measure of missed opportunities, no shows, and cancellations. And that is cancellations both by the patient and by the clinic. And that is, I want to be careful not to give the sense that that is used as a tool to drive——

Ms. KUSTER. Well let us not get into a situation where we pretend people show up who did not show up.

Dr. JESSE. But it is a practice management tool, so that individuals who have their own clinics can understand if they have a problem of all their patients not showing up, if there is a different issue. If practice managers are not leveraging using open slots, slots that come open because people say I cannot make that appointment, then that is not a very effective use of the clinician's time. So we do actually pay a lot of attention to this. We may not be as, some places as good as it is in the private sector. The private sector clearly has dealt with this very strongly because for them it is a revenue issue. But I would not say that we wait for people not to show up because it is a snow day. You know, our providers are busy and we want our patients in there. We worry about then when they do not show up if we are expecting them because, you know, and particularly in mental health. We track them down because we are worried that something might have happened.

Ms. KUSTER. Well my time is up. But it is something that I think if you could take back to your administration, this is a critical point and something that is extremely frustrating to all of us here. So——

Dr. JESSE. And may I thank you for your nice comments about the Manchester VA.

Ms. KUSTER. We are fortunate.

Dr. JESSE. My dad used the Manchester VA and he always thought highly of it.

Ms. KUSTER. We are very fortunate.

Dr. JESSE. Yes, you are.

Ms. KUSTER. Thank you.

Dr. JESSE. It is a good spot.

The *Chairman.* Thank you, Ms. Kuster. Mr. O'Rourke, you are recognized for five minutes.

Mr. *O'Rourke.* Thank you, Mr. Chairman. A month ago, just about, May 9th, I received this report from your predecessor, Dr. Petzel, and John Mendoza, the Director of the El Paso VA. And it is entitled, "Wait Time For Initial Visit to Mental Health Among Patients New to the VA." And it shows that right now zero patients are waiting longer than 14 days to see a mental healthcare provider. Actually, that was for March. And then for the month before that it was zero. And it was like that all the way through the last 12 months, where the longest average wait time was three days.

The audit that we got from the VHA this week shows that that same group, these are new patients seeking mental healthcare appointments, it is actually 60 days which makes El Paso VHA the fourth worst in the country. When we look at established patient

mental healthcare average wait times it is the absolute worst among all VHAs in the country. I want to know what the consequences are going to be for publishing false, inaccurate data. You know, I am sensitive to the comment that my colleague Ms. Titus made about saying that these are lies. But I do not know what explains it. And the consequences could not be more dire for the people depending on this. So I would like to hear concisely what the consequences are going to be.

Dr. JESSE. So we have had a little bit of a discussion about this. And I cannot say what the consequences are, because I do not know how it happened and by whom. And I think at the bottom of this is that we looked at data that we assumed to be correct, we did not challenge ourselves to find out that it was not until we got down and did this audit. So I do not, and I do not know that, you know, without looking into it and frankly this is why we have the IG and others do these investigations. If somebody deliberately misled you or anybody else on this data, there will be consequences. I am not a lawyer. I cannot speak to what those would be. So.

Mr. *O'Rourke.* Let me follow up with this.

Dr. JESSE. Sure.

Mr. *O'Rourke.* I also shared with you a survey that we did——

Dr. JESSE. Yes.

Mr. *O'Rourke.* —because it was such a discrepancy between what VHA has been reporting since I have been in office the last year and a half and what veterans are telling me. And we found in that statistically valid survey that 36 percent, more than one-third of the veterans that I represent, who seek mental healthcare appointments not only cannot get in within 14 days, they cannot get in at all. That to me is a crisis. When you have 22 veterans a day killing themselves in this country, when I learned from one of my constituents Bonnie D'Amico that her son, a veteran, came to one of my town hall meetings, heard veteran after veteran go up to the mike and say I cannot get in. On the drive home with his mom that night from the town hall meeting he said, you know, these guys are a lot older than I am. They have been trying to get into the VA system longer than I have. What does that say about my chances? Four days later he killed himself.

I think this is a crisis. And frankly I do not see the urgency from you. I do not see the commitment to accountability from you or others to address this. If I knew what you now know and I were in your position, I would fly down to El Paso immediately and try to discover who those 36 percent of the veterans seeking mental healthcare appointments who have been denied and locked out of the system are. You are not doing it. You know, we spoke the day after I released the report. We asked for a plan of action. We spoke then Monday of this week, we asked for a plan of action. I asked you before when we sat down, you said you were going to back to the office and take a look at this. I have been very patient and very cooperative in working with the VA. That has not served me or the veterans that I represent very well.

I understand you have a lot of demands on your time right now given what we have learned from Phoenix. But we have a crisis in El Paso and I would argue in many other places. But I have identi-

fied it for you. I have given you the information. I am willing to help you. I will use my own resources to track these folks down with you. But you have the list, the information, the veterans who have sought care and not been able to get it. When are going to get that urgency from you, and when are we going to connect them with the care that they deserve and that they have earned?

Dr. JESSE. So as I said when we spoke earlier, when I get back to the office I will get the final answer. I do not know why you have not gotten the plan yet. I would hope that by now all of the veterans would have been called. And as I said, my concern is the 36 percent number that you have in your survey. Because I am concerned about the ones that we know, but I know we can help them and get them in. I am really concerned about the ones that we do not. And how we reach out to then and ensure that, you know, people who think that they are waiting for an appointment, and somehow we have missed them, or dropped off. I do not know. I am really worried about them. And I have offered to come down. We will get a time and figure it out.

Mr. *O'Rourke.* Okay. I am going to use every opportunity I have when you or someone else from the VA or the VHA appears before us to press this issue. Because we know about it. You say that you have a commitment to it. We have yet to see a plan of action. I think we need a SWAT team flown down to El Paso to go connect these people. Again, I would like to be part of the solution. I offer myself and my office, our resources to that effort. But we need to get it done.

Dr. JESSE. And actually, I thank you for that. I very much appreciate you wanting to be part of that solution. Mr. *O'Rourke.* Thank you. Mr. Chair, I yield back.

The *Chairman.* Thank you, Mr. O'Rourke. I would like to read to you from Title 18, United States Code, Section 15.05.

It says, "whoever corruptly or by threats or force or by any threatening letter or communication influences, obstructs, or impedes, or endeavors to influence, obstruct or impede the due and proper administration of the law under which any impending proceeding is being had before any department or agency of the United States, or the due and proper exercise of power of inquiry under which any inquiry or investigation is being had by either house or any committee of either house, or any joint committees of the Congress, shall be fined under this title, imprisoned not more than five years."

This is serious stuff.

Dr. JESSE. Yes, sir.

The *Chairman.* And I hope the department gets it. Are there any other questions? Ms. Brownley?

Ms. BROWNLEY. One last question, at least for myself. In the earlier testimony today, well let me just say there have been a lot of recommendations made to this committee on how things can be improved. And I would certainly be curious to know how the VA is digesting that and how they are responding to it. But there was one I think compelling recommendation today to, you know, before we move forward with a major fix to this situation that we should first do with an outside consultant a cultural assessment within the VA. And I am just wondering, you know, what your reaction

is to that? What your response is to that recommendation to this committee?

Dr. JESSE. So the answer is absolutely, but more. Yes, the cultural piece is crucial. And culture is established by leadership. I think, you know, I take that very much to heart. The organizational structure and design was part of that discussion and again absolutely. And we have been over the past several weeks meeting with a number of people who work in this area, with expertise in this area, absolutely agree it needs to be done. We cannot redesign it ourselves. We need the input and you know I have been having a number of conversations with, for instance, folks at Kaiser. How does Kaiser's organizational structure, you know, seemingly to work well? How does Mayo's structure work well? How does Geisinger's structure work well? We need people who can see across those systems and, like Mr. Collard does and can, and bring that shared knowledge to bear to us.

So yes, we definitely plan on doing that. We will do it expeditiously.

Ms. BROWNLEY. Thank you. Thank you——

Dr. JESSE. We will include the veterans and the veterans services in that discussion as well, by the way.

The *Chairman.* If I can just in closing ask one question. In testimony that you presented to this committee in February of 2013, you stated that the Pittsburgh VA Healthcare System's copper silver ionization system may have failed to consistently prevent legionella growth. Do you recall that——

Dr. JESSE. Mm-hmm.

The *Chairman.* —testimony? But in a December, 2012 VA report, VA leadership was made aware that it was poor record keeping, lack of oversight and documentation, failure to test the hospital's water pH level, and other problems were at the heart of Pittsburgh VA's Legionnaire's disease outbreak. So now we know that it has led to at lest six preventable deaths at that facility. So explain to me how you could testify to Congress contrary to something that had already——

Dr. JESSE. So I was not aware of that report at the time I made that testimony. And I apologize——

The *Chairman.* Are you aware of the report today?

Dr. JESSE. What is that?

The *Chairman.* Are you aware of the report today?

Dr. JESSE. Yes.

The *Chairman.* Has anybody been held responsible for writing your speech, or intentionally misleading the Congress?

Dr. JESSE. Well, I do not know that anybody intentionally misled. I do not know where that said report was given to senior leadership. I do not know the trail on that report. And in fact, I was made aware of it only relatively recently. And so somewhere in the traveling of information it did not get widely distributed. I apologize. I do not know the answer to that, but——

The *Chairman.* Has the person that wrote your testimony been held accountable, now that you know about the report, and it does in fact contradict your testimony?

Dr. JESSE. Well I do not know that the person who wrote the testimony was aware of it at the time, either. And I do not know what

it means, that central office was aware of it. So I apologize. I do not know the answer to that.

The *Chairman.* But we do know——

Dr. JESSE. There was no intent to mislead, I assure you of that. I have always been——

The *Chairman.* But we now know your testimony was not in fact true.

Dr. JESSE. Well no, the testimony, the testimony is true. It is not complete, but it is true. You know, let me put a reference point on it. The CDC came in. They took extensive water samples. And in those water samples in fact the copper silver ion levels were at manufacturer's instructions levels and they grew legionnella out of them. So we know that in water samples that had appropriate cooper silver ion levels it failed to control legionella. And that has not happened just in Pittsburgh VA, it has happened in other hospitals. So.

The *Chairman.* Does it, I guess my question is, and this is, and again——

Dr. JESSE. Yes?

The *Chairman. This is pretty critical. But does it bother you that you testified to something, there was a report that differed from your testimony, and you were not provided that information?

Dr. JESSE. It bothers the heck out of me, yes, sir.

The *Chairman.* Okay. All right.

Dr. JESSE. Absolutely.

The *Chairman.* Thank you for being here. We thank the earlier panel for being with us. Thank you, members. And this hearing is adjourned.

[Whereupon, at 1:42 p.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT FOR THE RECORD

Letter From Robert Jesse to Chairman Miller

The Honorable Jeff Miller, Chairman

Dear Mr. Chairman:

Following the June 12, 2014, Committee on Veterans' Affairs hearing, I asked staff to confirm my response to a question by Ranking Member Michaud. When asked about the Veterans Integrated Service Network (VISN) structure; specifically "The VISN structure has been under scrutiny for a few years now. And I understand that VHA has reduced the number of headquarters staff through a realignment effort. Is that process finished?"

I would like to clarify my response where I stated that the size of the VISNs is "now between, I think, about 55 and 65." This is correct with the exception that VISN 16 was granted a waiver in February 2014, by the prior Under Secretary of Health to hire an additional 10 staff. VISN 16 is a large and very complex network of facilities with an influx of new leadership, and it was felt the VISN required additional staff to provide needed clinical and administrative support across the network.

I would ask that this letter be made an official part of the record.

Sincerely,

Robert L. Jesse, MD, PhD

Acting Under Secretary for Health

cc: The Honorable Michael Michaud